NHS Devon Integrated Care Board (ICB) meeting

Pomona House, Torquay

15 February 2023

10.00 to 12.30 hours

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Agenda for meeting in public

The quorum for meetings of the Board is :

a) Chair or Vice Chair
b) At least two Executive Directors
c) At least two additional independent members
d) At least one Partner Member
e) At least one of the members must be a registered clinician.

	Board pre-meet	**Lead**	**Action**	**09.45**
	Members Pre-meet	All members	Discussion	
	Introductory items	**Lead**	**Action**	
1	Welcome, introduction and apologies Apologies – Darryn Allcorn (Susan Masters deputising)	Sarah Wollaston, Chair	Discussion	10.00
2	Declarations of Interest	Sarah Wollaston, Chair	Noting	
3	Minutes of the meeting held on 18 January 2023	Sarah Wollaston, Chair	Approval	
	Citizen's Voice			
4	Citizen Story – Education Healthcare Plan (EHCP) process Neurodiversity Game Changer	Member of the public Hannah Pugliese, Head of Women & Children's Commissioning Dr Vicky Hill, Consultant Child & Adolescent Psychiatrist	Discussion	10.05
	Leadership	**Lead**	**Action**	
5	Chair's Report	Sarah Wollaston, Chair	Noting	10.30
6	Chief Executive's Report	Jane Milligan, Chief Executive Officer	Noting	10.35
7	Devon Workforce Challenges	Paul Renshaw, Director of Strategic Workforce	Noting	10.40
	Assurance and system oversight	**Lead**	**Action**	

8	Torbay Special Educational Needs and Disability (SEND) Strategy	Susan Masters, Deputy Chief Nurse	Endorsing	10.45
9	Urgent and Elective Care Recovery Plans	Anthony Fitzgerald, Chief Delivery Officer	Review and discuss	10.55
10	Integrated quality, performance, and finance report	Anthony Fitzgerald, Chief Delivery Officer Paul Renshaw, Director of Strategic Workforce Susan Masters, Deputy Chief Nurse	Noting	11.05
11	Committee Chair Report – Quality & Performance Committee, 1 February 2023	Hisham Khalil, Non-Executive Member	Review and discuss	11.10
12	Finance reports I. NHS Devon Month 9 report II. ICS Month 9 report	Bill Shields, Chief Finance Officer	Review and discuss	11.15
13	Committee Chair Report – Finance Committee, 1 February 2023	Kevin Orford, Non-Executive Member	Review and discuss	11.25
	Break			
	Governance and risk	**Lead**	**Action**	
14	Audit & Risk Committee 8 February – Verbal Update from the Chair	Kevin Orford, Non-Executive Member	Review and discuss	11.35
15	Committee Chair Report - Primary Care Commissioning Transitional Committee, 26 January 2023	Thandiwe Hara, Non-Executive Member	Review and discuss	11.40
16	Committee Chair Report - People & Culture Committee 25 January 2023	Thandiwe Hara, Non-Executive Member	Review and discuss	11.45
17	Cornwall and Isles of Scilly ICB Update	Kate Shields, Chief Executive Officer C&IoS	Noting	11.50
18	Action Log	Sarah Wollaston, Chair	Approval	12.00

Public Questions - on publication of the agenda, members of the public are invited to submit any questions related to agenda items no less than 2 days prior to the meeting to d-icb.governance@nhs.net. Appropriate questions and responses will be shared during the meeting and published on the website following the meeting				
19	Questions from members of the public	Sarah Wollaston, Chair	Discussion	12.05
20	Any other business	Sarah Wollaston, Chair	Discussion	12.20
	Close			**12.30**

Declaration of Interests Register -
Register updated and generated by the Governance Team

Register last updated 11 January 2023

Title	Surname	First name	Role or Position held with the ICB	Committees attended	Interests	Interests - Partner or Family	Date Interest from	Date Interest to	Date interest updated	Type of Interest	Is the interest direct or indirect?	Action taken to mitigate risks	Employer Organisation	Column1	Column2
Dr	Acheson	Nigel	Chief Medical Officer, Integrated Care Board	ICS Senior leadership team ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Quality and Performance Committee ICS Executive Committee ICB Senior Executive Team Devon Urgent Care Strategy Oversight Group Peninsula Acute Sustainability Programme	Director of H Smith Safety Associates Patron of the FORCE cancer charity in Exeter Director on the board of the South West Academic Health Science Network	Wife works as an associate with the South West Academic Health Science Network Relative consultant Dermatologist at the Royal Devon University Hospital In-law is a GP partner in the Woodbury Practice	05/10/2018		12/05/2022			Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB		
	Allcorn	Darryn	Chief Nurse	Quality and Performance Committee System Quality and Performance Group ICB Board Audit and Risk Committee (If Required) Quality and Risk Group ICS Executive Committee ICB Senior Executive Team Devon Urgent Care Strategy Oversight Group	Honorary Associate Professor University of Exeter Seconded to NDHT (to 18 September 2020) Strategic Chief Nurse, Nightingale Hospital Exeter System Chief Nurse, Devon STP		11/05/2020		01/02/2022	Direct	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB		
Prof	Asthana	Sheena	Independent Non Executive Director of Citizen and Community Involvement	Population Management and Health Inequalities committee ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee	Director, Plymouth Institute of Health & Care Research (PIHR). It is likely that members of my institute will undertake funded research for NHS Devon partners Trustee of Change Grow Live (a national charity that provides substance use, CYP, domestic violence, prison etc services. Devon does not currently contract services to CGL Member of the Advisory Committee on Resource Allocation (ACRA) which independently advises on NHS funding formulae Member of the project board of the proposed West End Health and Being Centre in Plymouth	Partner runs a research consultancy specilising in the integration and analysis of large data (inc NHS)	10/03/2022		10/03/2022				NHS Devon ICB		
	Braid	Helen	Head of Governance	ICB Board Audit & Risk Committee Organisational Re-Structure Programme Board Working with Industry & Sponsorship Group	No interests declared	N/A	13/11/2019		06/02/2023	N/A	N/A	N/A	NHS Devon ICB		
	Brown	Steven	Director of Public Health, Communities and Prosperity	ICB Board	No interests declared		19/11/2020		09/11/2022				Devon County Council		
	Clarke	Graham	Independent Non Executive Director of Audit and Risk	ICB Board Audit and Risk Committee NHS Devon Finance Committee Primary Care Commissioning Transitional Committee	Non-Executive Director of Medicine Discovery Catapult Non Execuitve Member at the Deparment of Health & Social Board Chair of HUC (East of England 111 and Urgent Care Provider) Trustee and Treasurer of the Cornwall Community Foundation	Spouse is CEO of Cornwall Partnership Foundation Trust and a Board Member of Cornwall & Isles of Scilly ICB	01/01/2020		04/08/2022				NHS Devon ICB		
	Cooper	Ann	Interim Strategic Governance Adviser	ICB Board Audit and Risk Committee	Contractor with TIAA ltd – internal audit services Bank contract as governance adviser with NHS Frimley		01/06/2022		24/11/2022			Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB		
	Davenport	Liz	Chief Executive Torbay and South Devon Trust	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Integrated Care Partnership Committee ICS Executive Committee	Director of Torbay Pharmaceuticals		24/11/2016		21/06/2022				Torbay and South Devon NHS Foundation Trust		

	Finn	John	Director Urgent & Elective Care	Devon Planned Care Programme board Devon Urgent Care Strategic Oversight Group LTP Programme Board LTP Programme Board Devon Urgent Care Strategic Oversight Group Senior Executive Team Devon ICB Board (when required) Devon Integrated Transport Board Peninsula Cancer Alliance Peninsula Acute Sustainability Programme	No interests declared	No interests declared	19/01/2017	03.01.2023				NHS Devon ICB
	Fitzgerald	Anthony	Chief Delivery Officer	NHS Devon Finance Committee ICB Senior Executive Meeting System Delivery and Improvement Meeting Risk Management ICB Board Session ICB Board ICS Executive Committee Vacancy Control Panel	No interests declared		15/11/2022	15/11/2022				NHS Devon ICB
	Green	Joanne	Interim Board Secretary	ICB Board	No interests declared							
	Hara	Thandiwe	Independent Non Executive Director of Inequalities and Population Health	ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee People & Culture Committee	Trustee of Plymouth and District Racial Equality Council, a voluntary organisation that work to promote race equality. member on the NIHR SW Clinical Research Network Board.		16/03/2022	16/03/2022			There should be no conflict of interest in current circumstances, but this may arise if, they became a provider during the course of time. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary. This should not raise any conflict, that I can foresee except that it is research related. There is no commissioning involved, but thought to mention it anyway. I will declare my interest at any meeting that may result in them being considered for service provision and leave the meeting if necessary.	NHS Devon ICB
OBE	Hargadon	Judy	Independent Non Executive Member Primary Care (Interim)	Member of Primary Care Commissioning Transition (PCCT) (Chair) ICB Board Remuneration & Internal ICB Workforce Quality and Performance Committee People & Culture Committee	Member of Women's Equality Party	Spouse is Chair of Dartington Hall Trust Brother is a GP in Cornwall	01/05/2019	14/07/2022	Financial / Personal	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Howland	Jodie	Governance and Facilities Business Manager	ICB Board One Devon ICP Partnership Board Audit and Risk Committee Building Coordinators Green Team Integrated Care Partnership Committee			11/02/2020	08/08/2022		Indirect	Any shift allocation that I am supporting with will be agreed and approved by a third party	NHS Devon ICB
Prof	Khalil	Hisham	Independent Non Executive Director of Quality and Performance	ICB Board Audit and Risk Committee Quality and Performance Committee	Practising Consultant in Derriford Hospital Limited Private Practice in Nuffield health Plymouth Director for Private Practice- Dormant Company Trustee of the Peninsula Medical Foundation		01/09/2004	24/02/2022				NHS Devon ICB
	Lee	Tracey	Chief Executive for Plymouth City Council	ICB Board Remuneration & Internal ICB Workforce	Director of Destination Plymouth Ltd		03/09/2022	13/09/2022				Plymouth City Council
	Lou Glover	Sarah	Ordinary Member for the Devon Integrated Care Board for Mental Health	ICB Board Remuneration & Internal ICB Workforce	Trustee of Honiton Health Matters who hold community conversations Director of Parental Minds C.I.C, for parents/caregivers who are supporting their child/family/friend with their mental wellbeing A Director, including a Non-Executive Director, or senior employee in a private company or public limited company or other organisation which is doing, or which is likely, or possibly seeking to do, business with health or social care organisations An advocate for a particular group of patients Ambassador Volunteer with DIAS Community group which may have potential to give rise to influence decisions made by the ICB.		28/06/2022	28/06/2022				NHS Devon ICB

Cllr	McInnes	James	Chair of One Devon Partnership Board (ICP)	ICB Board	Elected member of Devon County Council		2005	2025		General Interest		Where a piece of work or an item on a Board agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote	Devon County Council
	Milligan	Jane	CEO ICS for Devon	ICB Senior Executive Team Senior Leadership Team (SLT) Audit and Risk Committee (If required) ICB Board NHS Devon Finance Committee ICS Executive Committee Executive Workforce Committee People & Culture Committee Remuneration & Internal ICB Workforce (If Required)	Member of Cornwall and Isles of Scilly ICB	Partner Trustee for Action for Stammering	31/12/2020		21/06/2022	Personal	indirect	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	Millward	Andrew	Chief Communications and Corporate Affairs Officer	ICB Senior Executive Team Staff Partnership Forum Audit and Risk Committee (If Required) Vacancy Control Panel Equality, Diversity and Inclusion Group ICB Board Remuneration & Internal ICB Workforce Executive Strategy and Transformation Group ICS Executive Committee Executive Workforce Committee People & Culture Committe Peninsula Acute Sustainability Programme	Chair of Friends of Eggesford All Saints Trust, a registered charity. Fellow of the Centre for Communications Research, Buckinghamshire New University Non-Executive Board member of Delt Shared Services		19/06/2018		10/10/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB
	O'Kelly	Frank	Primary Care Partner for NHS ICB	ICB Board Primary Care Commissioning Transitional Committee Remuneration & Internal ICB Workforce	GP Partner at Amicus Health Blundell's School Lead Doctor Clinical Lead for STEER Education Member of the National Armed Forces Reference Group CQC Manager for Amicus Health Attends Tiverton High School Welfare Meeting fortnightly		01/01/1999		11/07/2022	Financial			NHS Devon ICB
	Orford	Kevin	Independent Non Executive Director of Finance and Remuneration	ICB Board Remuneration & Internal ICB Workforce Audit and Risk Committee NHS Devon Finance Committee Quality and Performance Committee	Non Executive Director on the board of Royal Devon and Exeter NHS FT (Ceased 30.06.22) Non Executive Director on the board of Northern Devon Healthcare NHS Trust (Ceased 30.06.22) Director and Majority Shareholder of Kevin Orford & Associates Ltd, which undertakes consultancy contracts with NHS organisations outside of the South West of England Non-Executive Director on the Board of the Intellectual Property office, a government agency in the Department of BEIS.		01/01/2012		15/07/2022				NHS Devon ICB
	Renshaw	Paul	Director of Workforce Stategy	ICB Board Audit and Risk Committee (If Required) ICS Executive Committee Executive Workforce Committee People & Culture Committee ICB Senior Executive Team Devon Urgent Care Strategy Oversight Group	Non-active Consultancy partner for Linea Consulting . No remuneration for this position. No work carried out for Linea to date. Quarterly online meetings take place out of normal business hours.i attend these occasionally		2018		10/10/2022	Partner	Direct	Any Conflicts of interest at meetings will be highlighted and would seek line manager approval for any work to be carried out prior to any taking place	NHS Devon ICB
	Tapley	Simon	Chief Transformation and Strategic Planning Officer	ICB Senior Executive Team ICB Senior Leadership Team Audit and Risk Committee (If Required) Vacancy Control Panel ICB Board NHS Devon Finance Committee Executive Strategy and Transformation Group Primary Care Commissioning Transitional Committee Eastern LCP Executive Group South LCP Executive Group ICS Executive Committee Peninsula Acute Sustainability Programme		Spouse is employed by TSDFT (ICO) 31/03/2017 Brother in Law is employed as Strategic Engagement Manager, NHS Devon ICB Step-son is a Receptionist at Albany Surgery	01/11/2016		04/08/2022	Non-Financial Interest Professional	Direct	Where a piece of ICB work or an item on a ICB Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

Dr	Wollaston	Sarah	Chair for ICS Devon	ICB Board Audit and Risk Committee (If Required) NHS Devon Finance Committee (If Required) Remuneration & Internal ICB Workforce Quality and Performance Committee People and Culture Committee Primary Care Commissioning Transition Committee	Trustee of Landworks, a Dartington based charity that works with ex offenders and people at risk of going to prison to support them into employment and reduce the risk of reoffending	Spouse is president of the Royal College of Psychiatrists and a consultant forensic psychiatrist employed by Devon Partnership Trust Relative is a registrar in Obstetrics and Gynaecology on the South West training scheme. Relative is a registrar in Anaesthetics on the south West training scheme and currently based at Derriford	26/11/2021	27/06/2022	Non-Financial Personal Interests	Indirect	Where a piece of ICB/ICSD work or an item on a Committee agenda item concerns an area where this person has declared an interest, they would be allowed to input their knowledge and experience but not participate in the final decision/vote.	NHS Devon ICB

NHS Devon

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Minutes of a meeting of NHS Devon Integrated Care Board held in public at Pomona House and via Microsoft Teams and livestream on Wednesday 18 January 2023 between 10am and 12.15pm	
*Name and initials (*voting member)*	*Title and organisation*
Board Members:	
*Dr Sarah Wollaston (SW) Chair	Independent Chair, NHS Devon
*Graham Clarke (GC)	Non-Executive Member, Audit and Risk, NHS Devon
*Thandiwe Hara (TH)	Non-Executive Member, People and Culture, NHS Devon
*Judy Hargadon (JH)	Non-Executive Member Primary Care, NHS Devon
*Hisham Khalil (HK)	Non-Executive Member, Quality and Performance, NHS Devon
*Kevin Orford (KO)	Non-Executive Member, Finance and Remuneration, NHS Devon
*Sheena Asthana (SA)	Non-Executive Member
*Jane Milligan (JM)	Chief Executive Officer and Accountable Officer, NHS Devon
Anthony Fitzgerald (AF)	Director of Delivery, NHS Devon
*Darryn Allcorn (DA)	Chief Nursing Officer, NHS Devon
*Bill Shields (BS)	Chief Finance Officer, NHS Devon
Andrew Millward (AM)	Chief Communications and Corporate Affairs Officer, NHS Devon
Partner Members:	
*Sarah-Lou Glover (SLG)	Mental Health Representative
*Tracey Lee (TL)	Chief Executive, Plymouth City Council representing local authorities
*Frank O'Kelly (FOK)	Primary Care Representative
*Steve Brown (SB)	Director of Public Health, Devon County Council
*Liz Davenport (LD)	Chief Executive Officer, Torbay and South Devon NHS Trust representing acute trusts
Guests in attendance:	
Helen Braid (HB)	Head of Governance, NHS Devon
Karen Cook (KC)	Chair, Livewell SouthWest
Joanne Green (JG)	Interim Board Secretary, NHS Devon
Jodie Howland (JHo)	Governance Business Manager, NHS Devon
Cllr James McInnes (JMc)	Chair Devon Integrated Care Partnership
Mark Sowden (MS)	Associate Director of Workforce
Jo Turl (JT)	Director of Primary care, Community, Mental Health, and Children's Services
John Finn (JF) *minute 5 only*	Director of Urgent and Emergency care
Dr Helena Posnett (HP) *minute 5 only*	Acting Consultant for Public Health
Dr Claire Hooper (CH) *minute 5 only*	Strategic Lead for Planned Care
Apologies for absence	
*Nigel Acheson (NA	Chief Medical Officer, NHS Devon
Paul Renshaw (PR)	Director of Strategic Workforce, NHS Devon
Kate Shields (KS)	Chief Executive Officer, Cornwall, and Isles of Scilly ICB
Simon Tapley (ST)	Chief Transformation & Strategic Planning Officer, NHS Devon

Minute number	
1	**Welcome and Apologies for Absence** The NHS Devon Chair, Sarah Wollaston (SW) welcomed those in attendance at the NHS Devon board meeting being held in public. It was acknowledged that due to technical issues the meeting had been moved from Plymouth to Torquay but would be returning to Plymouth in April. A particular welcome was extended to Karen Cook, Chair of Livewell Southwest who joined as part of a programme where Chairs from across the system would join the public meetings as part of integrated working. Apologies for absence had been received from the Chief Medical Officer, Nigel Acheson, Director of Workforce, Paul Renshaw, Chief Transformation and Strategic Planning Officer, Simon Tapley, and the Chief Executive of Cornwall, and the Isles of Scilly, Kate Shields. A welcome was extended to Mark Sowden and Jo Turl who were deputising for Paul Renshaw and Simon Tapley respectively. It was shared that the Chief Executive Officer, Jane Milligan (JM) would need to step out of the meeting at around 10.15am for an hour to attend a Hewitt review meeting. The meeting was deemed quorate. It was advised that immediately after this meeting the Board would meet in a private session to discuss the upcoming National board to board meeting and the Board Assurance Framework.
2	**Conflicts and Declarations of Interest** Members noted the Conflicts of Interest Register which had been circulated as part of the meeting pack. No new declarations were made.
3	**Minutes of the previous meeting held on 21 December 2022** The minutes of the above-mentioned meeting were approved as an accurate record.
4	**Citizen's Voice** SW introduced a short film around the experiences of and including an interview with an asylum seeker resident in Devon as well as staff from the local charity SeaChange based in Exmouth who have been supporting them. Dr Barry Coakley (BC), General Practitioner, Clinical Director of the Local Primary Care Network and Chair of the Primary Care Collaborative Board, talked about the Asylum Seeker and Refuge Programme and his experiences as a professional in supporting people within the bridging hotels. BC was pleased to be able to share some of the learning captured for other areas of the system. Three key areas were noted when people arrive which was to welcome, orientate and register. The welcome and orientation would enable a human relationship to develop and people to know and understand where they are and where they would access support if needed. The next stage would be to register each person and provide them with an NHS number to allow health care to begin straight away. Once people are registered a health screening would be undertaken to identify any health care needs including immunisation. BC observed that it was once settled that mental health concerns can surface so to ensure there is an open door policy is helpful. Further support was discussed including food, transport, and language barriers. Dentistry was highlighted as a particular issue. The Mental Health Partner Member, Sarah Lou Glover (SLG), acknowledged the invaluable work the charity SeaChange provides to this area and asked if there is funding for these charities to continue supporting in the future. BC confirmed funding for support was through Devon County Council for as long as the bridging hotels are being used. SLG also asked if mental health services had been received to date. BC confirmed the mental health support had been through the same referral process used for everyone.

	Non-Executive Member Judy Hargadon (JH) asked if there were concerns with people being moved once settled. BC confirmed he had not come across this issue within his practice but Non-Executive Director, Frank O'Kelly (FOK), who is also a General Practitioner in Tiverton, was able to share that it did happen within his practice after spending a lot of time supporting and getting people set up with services. Non-Executive Director, Dr Sheena Asthana (SA), suggested that people could be supported further by digital technology both for accessing care and for communicating with other asylum seekers to relieve isolation. Partner member, Tracey Lee (TL), shared that she held the Regional Lead for Migration and that there were five schemes for refuges and asylum seekers. It was confirmed there were different arrangements for different groups but that this was being reviewed in the South West. A note would be circulated to the board. **Action – Asylum seeker programme to be included on forward planner to discuss further.** SW thanked Barry Coakley and SeaChange for their continued work in this area. BC and JM left the meeting.
5	**Reducing and Mitigating Health Inequalities in planned care** The Director for Urgent and Emergency Care, John Finn (JF) introduced Drs Claire Hooper (CH) and Helena Posnett (HP). CH talked to the paper which had been shared as part of the meeting papers and requested the board note the content of the paper. The paper detailed the health inequality requirements in elective care for 2022/23 set by NHS England. Following a slippage in performance around this area of work CH shared that there had been an agreement to identify a named individual within each trust who would have the responsibility for this area of work. There would also be a working group who would oversee the delivery of the work plan. There had been a further agreement that the must do work outlined in the paper would be completed by the end of March. Timescales of work were shared. It was highlighted that one of the must do areas, the Equality and Health Inequalities Impact Assessment (EHIA), would not be completed until February and therefore would be fed back in March. SA highlighted there would be areas which could cause issues in this work and asked if the comorbidity is being controlled which can account for differences seen. It was also highlighted that historically ethnicity was not well coded which had caused issues. HP acknowledged that ethnicity coding needed improvement as well as other areas and shared that there is work happening with the Devon Intelligence Function Group to provide a baseline to be able to consider collectively how data can be improved. It was also shared that there would be a system wide group with data intelligence experts developed to work on a methodology based on work started by University Hospitals Plymouth. There was a challenge made by SA in the use of the word ethnicity to be used rather than BAME, which can be offensive. HP confirmed the use of BAME was an oversight in the paper and that ethnicity is used within NHS Devon. Partner Member, Stephen Brown (SB) asked how the system would learn from this work to support other areas of work within the health and care system. It was confirmed that within the EHIA element of the programme there are colleagues who will look at strengthening information and learning around inclusion groups. It was also confirmed that Children were included within the work. As part of the work there were requests from members of the board to understand what the next steps would be, how the work would change the decision making process for adding someone to a waiting list and how it would connect to impact on the economy. CH confirmed

	that in terms of waiting lists the Heart tool was being reviewed which is a piece of software which would enable local parameters to be set but currently clinical priority is used. SW asked whether consideration was being given to the impact of private investigations if these are differently accessed to expedite pathways of care HK highlighted that people with learning disabilities and mental health concerns do not feature within the paper presented to the board. HP confirmed that these groups will be included. The report was **noted** by the board. JF, CH and HP left the meeting.
6	**Chair's report** The report was taken as read and **noted** by the board.
7	**Chief Executive's report** The report was taken as read and **noted** by the board
8	**Operational Pressures** The Director of Delivery, Anthony Fitzgerald (AF), shared that today saw South West Ambulance Trust, after 598 days of being at escalation level REAP black, de-escalate to red. This had been the result in a sizable reduction of attendances to accident and emergency over the previous weeks. It was shared that January had seen an improved picture to that which had been experienced in previous years. NHS Devon had though, been in critical incident status twice over the last month. This was due to an increase in category two waiting times. Following these episodes learning has been reviewed and plans and processes have been put into place to enable new ways of working to be implemented to support the system. December brought other pressures by way of industrial action and Covid being a factor in staff illnesses. Modelling shows a peak of Covid in February which will be planned for. Discharge numbers have been reviewed and a discharge fund of £4.237m has been allocated to Devon to support bedded capacity. With this funding comes a huge reporting infrastructure. Localities will take the lead and work with trusts, but to spend the funding before the 31 March will be a challenge. Plans have been made coherent and communication across the system has been streamlined to ensure there is a single point of contact across the system. LD commented that supporting community services is important and that on top of that within the acute sector the balance is on protecting the capacity to deal with the planned care back log as well as managing the front door. FOK highlighted the funding is now the third tranche of funding this Winter, being directed at acute services and challenged the board to work creatively to ensure primary care can also be supported. AF confirmed that the system will work as creativity as possible within the strong criteria for use of the funding. JMc commented that reporting infrastructure can cause issues and reduce innovation. AF shared that learning from previous work has been used and there would be heightened governance around the reporting infrastructure. GC asked where NHS Devon were with virtual wards. AF confirmed the system committed to delivery 90 plus virtual wards but do to being unable to staff this. There are currently 20 virtual ward beds in use with a further 50 due to open in February. **Action – AF to provide feedback the after action review of operational changes, discharge funding evaluation and virtual ward progress at the next meeting.** SW thanked staff across the system who have been working under such conditions.
9	**Quality and Performance Committee update** Non-Executive Member, Hisham Khalil, (KH) highlighted the escalations set out within the paper presented as part of the papers of the meeting. Positive improvement was noted on the Integrated Quality, Performance and Finance report. It was shared the next meeting of the committee would be a development session to refine approaches to deep dives.

10	**Integrated Quality, Performance, and Finance report** The Chief Nurse, Darryn Allcorn (DA) talked to the report which was included as part of the papers for the meeting and highlighted the following areas. Category two ambulance responses and the differences across the system. The reduction in ambulance attendances to emergency departments has decreased however the demand on the departments has not. There has been an improvement in medically fit for discharge patients but the length of stay in hospital has increased. The two week waits cancer diagnostics are not improving and there has been a significant increase in referrals. It was acknowledged that primary care has worked hard to increase capacity with increased appointment availability, but the demand continues to outweigh the ability to see patients. NHS 111 have seen sustained improvements in call answering. Mental health has seen deterioration in terms of eating disorders access and access to dementia referrals have increased. There is sustained improvement in physical health checks within the mental health service. Infection control had been challenging, particularly Covid, Influenza A, Norovirus and Clostridium r difficile. There is a system wide focused piece of work to review inpatient setting falls following an increase in these serious incidents. Despite pressures the system had been a decrease in the number of contacts with the Patient Advice and Liaison Service. There had been an increase in safeguarding adult enquiries around quality of care. JH challenged the fact that there had been only 20 virtual beds opened and commented that when funding is received for institution and community based services that community services take much longer to implement. FOK commented that it would be useful to understand the productivity of the ambulance crews. DA agreed there is work required to ensure the directory of services is right and how as a system we can support their productivity however it was pointed out that SWASFT have relatively high levels of see and treat, which reduces the conveyance rate compared with other systems. SLG challenged around longer lengths of stays and asked if the community hospitals were still available would some of these patients be being supported within then. DA responded that many of the patients who would have been patients at community hospitals are now looked after within nursing homes and the length of stay is around the complexity of patients being admitted to hospital who do need that extra time. SA challenged that the report did not focus on the experience of people rather it gave a sense of externally imposed targets. There was a concern that the report would take away the focus of better solutions. DA confirmed there would be work with Healthwatch to see how experiences can be captured. SW asked if there had been an increase in the number of readmissions due to discharging patients as quickly as possible. DA confirmed that readmissions are monitored but had not seen an increase. JM rejoined the meeting at 11.34am. The board **noted** the report.
11	**Finance Committee update** Non-Executive Member, Kevin Orford (KO), provided a verbal update of business discussed at the Finance Committee on 11 January. In attendance at the meeting was the regional direction of operational finance who had expressed an interest in the committee scrutiny of the revised financial forecast. Three items from the meeting were highlighted.

	The re-forecast of the financial position was scrutinised and particular note was taken of the events work that has been undertaken across all organisations within the system to minimise the extent of the year end deficit which included a peer review exercise. Detailed assurance was received that the set forecast will not deteriorate any further between now and year end and each of the three NHS organisations that would be in deficit have all signed to confirm compliance with the NHS England reforecasting protocol. Under delegated authority, a business case had been approved for support to meet the NHS Financial framework in the future whilst ensuring access to high quality services. Assurances were provided on the timescale and process of the development and agreement of the operational plan.
11	**ICS and ICB Month 8 finance reports** The month 8 financial reports were taken as read. It was highlighted that the information would be different from these reports to the information contained within the financial forecast report which is in relation to month 9. The board **noted** the reports
12	**Financial Forecast** The Chief Finance Officer, Bill Shields (BS) talked to the paper that had been shared within the meeting pack. BS informed the board that the financial position showed deterioration from the plan signed off in July 2022, which was an £18.2m deficit, lying solely within the Royal Devon University Hospitals Foundation Trust (RHDU). It was updated that the positions within the other acute organisation had also deteriorated which had led to a requirement to reforecast. It was pointed out that the reforecast is a significant movement from £18.2m to £49.5m. It was highlighted that there had been a change to the figure from that discussed in a private session of the board in January due to having received additional monies which are required to be reported. To achieve the new position the NHS Devon will move from a break even position to report a surplus of £4.635m which would allow movement within the system. Devon Partnership Trust remain forecasting to produce a break even position. Regional finance colleagues had been fully engaged in the process and following detailed review the reforecasts had been signed off by the Finance Committee Chair, the Chair, the Chief Executive and Chief Finance Officers of each organisation. The revised deficits for each of the acute trusts were provided. RDUH - unchanged planned deficit of £18.263m. United Hospitals Plymouth (UHP) – £17.250m deficit. Torbay and South Devon (TSD) – £18.622m deficit. Devon Partnership Trust (DPT) - breakeven The board were reminded that the position had been due to a shortfall in the Capital Improvement Plan (CIP) delivery of £31.38m which is a significant issue to be addressed as well be increased inflationary costs of £7.3m and several other issues highlighted in the paper. BS informed the board that following discussion with regional colleagues the optimal time to reforecast would be month 9 and that any deterioration from the month 9 position is seen as a further failure of the system and organisation to forecast and deliver. The operational planning and oversight group will have oversight of the plans with a reporting mechanism to escalate to the executive finance and performance group who monitors the current fiscal year and the plan for the coming fiscal year. To reforecast there had needed to be signed protocols from each board and finance committees to confirm compliance, a report to NHS executives to support the change in forecast which was confirmed at the finance committee by regional colleagues that the report presented there covered the action and regional finance colleagues to have been invited to the finance committee. All actions were confirmed to have been completed.

	BS confirmed that the new forecast still has significant risks attached to it. Executive oversight will continue, and system Chief Finance Officers will continue to meet regularly to ensure any intelligence received can be acted on quickly. JH requested a level of confidence from BS on being able to stay within the forecast. BS was able to provide assurance on the position to be delivered. TL commented that as a board the oversight and understanding of any strategic changes because of the financial position would be helpful. BS responded that in the current fiscal year there would be huge changes it would however become difficult in the next fiscal year and the year after. The board formally **noted** that the financial forecast is now £4.635m surplus for NHS Devon and £49.5m deficit for the Integrated Care System approved by the Finance Committee on 11 January 2023. And **noted** the need for ongoing management of the system financial position throughout quarter 4.
13	**Assurance Committee - updates and escalations** The Board received and noted the following reports from its committees: ***Audit and Risk Committee*** The report from the December meeting of the committee was taken as read. Non-Executive Member, Graham Clarke (GC), shared that the committee is planning on moving from monthly meetings to six a year as part of the governance review. There remained a proposal for a system risk workshop which is in the planning phase. An update on the external auditor position was discussed which confirmed there would be a firm to complete both the CCG last three month accounts and NHS Devon accounts for this year and next. The board were made aware that there would be a significant increase in the fee for this work which would not be until August 2023. ***Primary Care Transition Commissioning Committee*** Report was taken as read. No escalations were offered.
14	**Cornwall, and the Isles of Scilly Board update** The board **noted** the report.
15	**Action log** The action requested to be closed was **agreed.**
16	**Questions from members of the public** No questions had been submitted.
17	**Any Other Business** The next meeting will be 15 February, held again at Pomona House, Torquay.

Minutes approved	Date:	Signed by chair:

NHS Devon Integrated Care Board

Report of the ICB chair

Date of committee	Date report produced
15 February, 2023	6 February, 2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Dr Sarah Wollaston, ICB chair
Phone:	-	**Date:**	6 February, 2023
Email:	Nick.pearson@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

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Executive summary

This document represents the chair's report and includes updates on the Integrated Care Partnership Board, new GP services, the Peninsular Pathology NHS Network and recent visits / speaking engagements.

The report is for information only.

Committees that have previously discussed/agreed the report, and outcomes of that discussion

-

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. For information only

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	**Reporting only**
Objective 2	**Reporting only**
Objective 3	**Reporting only**
Objective 4	**Reporting only**

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
Health inequalities	None
Workforce	None
Resources and finance	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

Report of the NHS Devon chair

Integrated Care Board

15 February 2023

One Devon Partnership

The One Devon Integrated Care Partnership met again this month.

Members received an update on system pressures, including in mental health, primary care, acute and in our Locality Care Partnerships.

It's clear that demand on services remains high in most areas, although the urgent and emergency care position has improved in Torbay, particularly since the opening of the new acute medical unit.

Detail was provided on the Devon System Senior Leadership Development Programme, which will see leaders working together across the system to strengthen collaboration through an "Outward Mindset" approach.

I was pleased to hear that five people have already commenced the training to become Outward Mindset trainers, enabling them to help others in the system.

The programme has been very helpful in other Integrated Care Systems and clearly focused on how this approach leads to better results for the individuals and communities we are here to serve.

A representative from the Voluntary Community and Social Enterprise (VCSE) updated the One Devon Partnership on the work of the VCSE assembly. This will play a key role in networking and involvement with a wide range of partners across Devon

Working groups have been set up to feed into the assembly with it working as a single point of contact for any requests in relation to service transformation.

The board also heard from Kristian Tomblin, Head of Inequalities for NHS Devon and Chair of the Devon Trauma Network, John Slater who set up and runs MoMENtum, Lizzie Vooght at Torbay hospital and Jonathan Borrett from Devon and Cornwall Constabulary on the importance and benefits of a trauma-informed approach across the Devon System. An example of this working is set out later in this report. The Partnership signalled its intention to return to this issue.

GP Services

I'm very pleased to report the opening of two new GP practices at Brixham Hospital next month - improving access to services for people in Brixham and surrounding areas.

Compass House and Mayfield Medical Centre are to co-locate at the hospital site, after a period of refurbishment, to offer GP services.

Mayfield Medical Centre, who took on the contract for the St Luke's site in Brixham, had to make the difficult decision to temporarily close the Brixham site at the start of the pandemic as it didn't meet the necessary safety measure for infection control.

This meant that people registered with the practice who needed to be seen, had to travel to neighbouring Paignton for GP appointments.

With financial support from Brixham Hospital League of Friends, patients of both practices will now access GPs, phlebotomy, nurses and healthcare assistant appointments at Brixham Hospital as both practices expand their service.

Torbay and South Devon NHS Foundation Trust operate the site at Brixham Hospital and are keen to use community health and wellbeing centres, community hospitals and diagnostic hubs to better support people closer to home and invest in local communities.

Thank you to everyone who has worked to make this possible.

Plymouth Care Hotel

A 40 bed 'Care Hotel' has been set up by health and care partners in Plymouth to help relieve pressure at the city's hospital by allowing faster discharge for people who no longer need to be in hospital but who are not quite ready to live fully independently at home.

Guests staying at the Care Hotel are cared for by a registered care agency, Abicare, and are supported to regain their independence, with some returning home without the need for ongoing social care.

Care hotels have been used by NHS Devon since 2020 and are just one of many positive measures health and care partners have put in place to help address the urgent challenge of delays to discharges and the knock on effect on ambulance transfers.

I look forward to visiting later this month to meet people who are using the service as well as those who are providing the service.

Peninsular Pathology NHS Network

I wanted to provide a brief update in the work of the Peninsula Pathology NHS Network.

The Network brings together the pathology departments across Devon, Cornwall and Isles of Scilly's NHS acute trusts to provide high quality data-driven, state-of-the-art pathology that supports clinical services and patients in our area.

The Peninsular Pathology NHS Network has attracted more than £13 million to Devon and Cornwall and the Isles of Scilly for projects which help laboratories run more efficiently, increasing productivity and helping to give patients test results more quickly.

Over the course of an average year the network's pathology departments process a combined total of 39 million tests a year, with an average of over 80,000 coming from each GP practice.

There are more than 800 pathology laboratory staff in the peninsula who play an essential role in helping to diagnose or rule out health conditions and infections, to identify the most appropriate treatment and to provide ongoing monitoring of health conditions.

Funding comes from NHS England's Digital Diagnostics Capabilities (DDC) Programme and covers the next three financial years. It includes more than £10 million for Digital Pathology and other digital maturity projects. There is also more than £3 million for Laboratory Information Management System (LIMS), which integrates with pathology data systems and helps to improve efficiency in labs, improve standardisation and interoperability across clinical systems.

The funding recognises the pioneering work in pathology departments in Devon and Cornwall and its ongoing potential. It will enable staff to process samples more quickly, with increased safety and efficiency.

Treatment Starts at Home

NHS Devon recently launched a new campaign called "Treatment Starts at Home", which gives simple advice on how to care for yourself for the most common minor conditions, such as sprains, ear infections and insect bites.

The campaign aims to reduce pressure on busy Emergency Departments, GPs, Urgent Treatment Centres and Minor Injuries Units and to help people avoid a potentially long wait.

Treatment for minor conditions starts at home and further advice can be sought through a pharmacy, which has the expertise and medicines available to help. The campaign also encourages people to go on the NHS website for advice on self-care.

It is hoped that the campaign will help individuals manage some of these more minor illnesses and conditions at home, to provide them with greater comfort but also to ease ongoing pressures.

Interpersonal Trauma and Violence Service

A scheme to help GPs and their teams to recognise the signs of domestic or sexual abuse launches in Devon in April.

The Interpersonal Trauma and Violence Service will be rolled out at all GP surgeries following a successful pilot.

Interpersonal abuse is associated with a range of mental and physical health conditions, suicide, homicide, increased medication and increased use of secondary care.

People can be referred by GP teams into the commissioned support service which works with adults affected by abuse, children affected by domestic abuse and adults concerned about their own abusive behaviour.

Staff affected by abuse can also self-refer into the service.

Interventions to improve safety and reduce trauma symptoms have led to clear benefits for individuals but have also meant that almost nine out of ten patients in the pilot reported that they had less need to see their doctor.

I am looking forward to speaking at the Interpersonal Trauma Response Service Stakeholder Event in March.

Many thanks to Collette Eaton-Harris for her work in establishing this service and to all those who have championed the need to take a trauma-informed approach across the Devon System.

Chair's visits and speaking engagements

It has been a good start to the year.

Jane Milligan and I spent an afternoon meeting with MPs in London, where we provided updates on the current position in Devon and discussed a range of constituency-level and Devon-wide topics. This was also an opportunity for elected representatives to discuss in person the draft Integrated Care Strategy.

I was pleased to visit Bramble Down Nursing Home in Denbury, towards the end of January to meet with representatives of the Devon Care Homes Collaborative (DCHC), which provides support to care home providers, managers and staff across Devon, Plymouth and Torbay. DCHC represents 67% of care homes including both nursing and residential homes.

As well as visiting Bramble Down, helpful discussions were had around transfers of care, funding and ongoing engagement. It was clear from discussions that there is further to go on improving the quality of information that accompanies people moving to residential and nursing home settings from hospital. This is an important patient safety issue and improving this would also help provide greater confidence for homes to facilitate discharge from hospital at weekends. I am grateful to DCHC for their commitment to assisting NHS partners to improve these important communications and I look forward to the board reviewing progress on this issue.

I also visited the Seachange Hub in Budleigh Salterton, a local Community Interest Company which operates out of the former community hospital.

The hub provides support to people in Exmouth, Woodbury and Budleigh Salterton and seeks to bring together residents, the NHS, the voluntary, statutory and business sectors under a common purpose to improve the quality of health and wellbeing.

It offers a wide variety of health and wellbeing support through fitness, social activities and NHS outpatient services.

It was great to see the hub in operation and meet so many people involved in this excellent project.

I would like to express my thanks to everyone at the Seachange Hub for welcoming me into the project and for their innovative and inspirational work..

I’m looking forward to visiting more projects and initiatives in 2023.

NHS Devon Integrated Care Board

Report of the Chief Executive

Date of meeting	Date report produced
15 February 2023	6 February 2023

Author(s)		Report approved by	
Name and title:	Nick Pearson, chair and chief executive's office	**Name and title:**	Jane Milligan, Chief Executive
Phone:	-	**Date:**	6 February 2023
Email:	Nick.pearson@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
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Executive summary
This document includes summary updates on Covid-19, Flu and vaccinations, industrial action, National Team visits, discharge funding, system pressures, the Operating Plan and the Patricia Hewitt review.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
-

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. The Board is requested to note the report

Impact on NHS Devon objectives	
Objective	**Impact**
Objective 1	Reporting only
Objective 2	Reporting only
Objective 3	Reporting only
Objective 4	Reporting only

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	None - reporting only
Health inequalities	None
Workforce	None
Resources and finance	None
Legal	None
Digital and Data	None
Engagement and consultation	Engaging communities and stakeholders in our work

NHS Devon Integrated Care Board

Report of the Chief Executive

15 February 2023

Covid-19 and Flu Update

The number of people in hospital with Covid-19 peaked at 185 on 31 December before dropping to 65 in mid-January. However, these numbers started to rise and stood at 141 at the end of the January – so we are not yet out of the woods with Covid-19 continuing to impact on our services.

This is set against a phenomenal effort in our vaccination programme where a total of 3.55m doses of Covid-19 vaccine have been administered in Devon alone, including more than 470,000 Autumn/Winter boosters.

The offer of an Autumn/Winter booster has now come to end. In addition to this, the booster for all 16 – 49-year-olds who are not considered at risk also ended at the same time as the autumn's campaign. First and second doses will remain available to those who would like them.

Social care staff are being urged to have their Covid and flu vaccinations if they haven't already. Nationally, the hospitalisation rate for flu patients has been increasing, with over 5000 people in hospital with flu across the UK in recent weeks. Health and social care workers, or unpaid carers or personal assistants to a friend or relative are particularly at risk of catching flu or Covid-19.

All workers, carers and personal assistants are being asked to consider getting booster vaccines for additional protection for themselves and the people they care for.

The flu vaccine has generally had a good uptake in the South West in comparison with the rest of the country, but numbers are lower than last year.

National data indicated that there was a demand across GP and Emergency Departments for a number of seasonal conditions in the period up to Christmas, there are signs that they are starting to decrease.

In an effort to further increase take up, the One Devon Integrated Care Partnership has produced a range of short films. These feature care workers, explaining why they decided to get vaccinated. Videos have also been created to support vaccines and health checks for people with learning disabilities, as they may be more vulnerable to both viruses.

System Pressures and Industrial Action

There has been a slight easing of pressures across the system recently.

This is good news considering there have been strike days for ambulance and nursing staff throughout December and January.

The number of people attending Emergency Departments has decreased, helping to ease pressures at hospitals and increasing the number of ambulance handovers.

However, there has been a daily escalation from mental health providers relating to delays in bed availability post assessment and challenges in achieving good discharge numbers at both Royal Devon University Healthcare Trust (RDUH) sites, which colleagues are continuing to work on.

It remains a difficult time, but we continue to take steps to ease those pressures and I would like to express my thanks to all staff for their continued efforts.

Industrial action continued during January, with nurses and ambulance workers striking on various dates.

Impact on urgent and emergency care showed that ambulance call outs and attendance to Emergency Departments were at the lowest level for some months. The nursing strikes in January did not affect Devon, but Somerset and Cornwall were included in the action.

Further strikes have been announced in both the healthcare sector and other industries across February and March. All acute providers in Devon, including South Western Ambulance Service NHS Foundation Trust are involved in the February action.

Derogations remain in place to ensure that the level of disruption to urgent and emergency care, together with community services, is kept to a minimum.

We will continue to collect data to understand the numbers of staff taking part in the industrial action, and the total number of staff due to be at work.

In addition, the data we collect will provide information on elective inpatient and outpatient activity that has been rescheduled as a result of the industrial action in all acute trusts.

Urgent and Emergency Service Recovery Plan

NHS England have recently published the joint NHS and Department of Health and Social Care (DHSC) Delivery Plan for Recovering Urgent and Emergency Care Services.

The aim of the plan is to raise the standards of quality and safety for the most vulnerable patients and their families. This ultimately means increasing the size of

the workforce, but also improving conditions for staff and enabling people to work more flexibly to meet the needs of patients.

The plan sets out actions across five key areas:

1. Increasing capacity;
2. Growing the workforce;
3. Improving discharge;
4. Expanding and better joining up health and care outside hospital;
5. Making it easier to access the right care.

In order to support the recovery plan, the government has committed to additional targeted funding including £1bn of dedicated funding for 2023/34 to support capacity in urgent and emergency services and to increase their overall capacity and support their staff, and £1.6b of additional funding in the Adult Social Care Discharge Fund in 2023/24 and 2024/25, to be pooled into the Better Care Fund.

It is intended that the plan will be delivered over the next two years.

Planning Process for the Devon Operating Plan

Chief Finance Officer, Bill Shields, and his team have been given a mandate to lead the Devon Operating Plan across the system.

The 2023/24 national priorities and operational planning guidance reconfirm the ongoing need to recover core services and improve productivity, making progress in delivering the key NHS Long Term Plan ambitions and continuing to transform the NHS for the future.

The guidance sets out three key tasks for 2023/24:

1. Recovering core services and productivity;
2. Delivering against the key ambitions in the NHS Long Term Plan; and
3. Continue transforming the NHS for the future.

There is an expectation that Integrated Care Boards (ICBs) work with their system partners to develop plans to meet the national objectives set out in the guidance and the local priorities set by systems.

The deadline for the draft Operational Plan to be submitted is 23 February, with the final Operational Plan to be signed off by the Board, partner trusts and foundation trust boards by 30 March 2023.

We continue to support Bill and his team to meet the required deadlines.

Discharge Funding

The government has recently announced a national £200m fund for local health and care systems to buy extra beds in care homes and other settings to help discharge

more patients who are fit to leave hospital and free up hospital beds for those who need them.

An additional £50m of capital funding is also being made available nationally to upgrade and expand hospitals, including new ambulance hubs and facilities for patients about to be discharged.

I am pleased to report that Devon is set to benefit from £4.2 million from the fund.

NHS Devon ICB has subsequently received a letter from NHS England confirming the allocation and guidance on how to spend it.

This letter has been sent to our Chief Delivery Officer, Anthony Fitzgerald, who is in the process of reviewing the detail. A further update will be available to the Board in due course.

Workforce

There's a good deal said about the workforce situation and how we need to get many more people into the NHS. What is less spoken about is social care and the problems colleagues are having in filling vacant posts here.

Our system-wide international recruitment hub historically focussed on nurse recruitment – and has been very successful in this.

It has now commenced a recruitment campaign on behalf of social care with the aim of recruiting up to 175 care workers by May 2023.

This ICB-funded programme saw the first five new social care recruits arrive in January with many more to come.

Future campaigns by the hub will be subject to agreement on where the accountability sits to ensure market sufficiency and where future costs associated with this kind of work should sit.

Discussions are underway between health and social care colleagues to agree what additional activities could be moved from health to some social care colleagues under third party delegations from 2023 onwards.

The aim of this work is to establish what additional services (for example basic wound care) some social care colleagues could deliver, which would enable health colleagues to focus on other activities. This work would also aim to improve attraction and retention in social care.

In addition, partnership working between the ICS, specialist social care recruiter Recruitment by AP, and the Devon Care Home Collaborative has resulted in successfully filling 20 social care nursing vacancies within 8 weeks.

The pilot project will see the nurses come to England from overseas before undertaking vocational training designed by social care providers through Indago Development.

I am pleased to see a project to have a consistent staffing bank model which will also have a significant impact on our agency expenditure has been agreed for roll out across our health providers during 2023/24.

This is very timely since we have challenging agency reduction targets to achieve as part of the operational plan for next year.

Patricia Hewitt Review

I had the pleasure of feeding into the recent Patricia Hewitt Review Roundtable Event. This includes the creation of the following national workstreams which start meeting at the end of January:

1. Prevention and population health management;
2. Integration and place;
3. Autonomy;
4. Accountability and Regulation;
5. Productivity and Finance; and
6. Digital and data.

The intention is to produce a report by the week commencing 20 February and I look forward to receiving the same.

National Team Visits

NHS Devon was pleased to host Professor Julian Redhead, the National Clinical Director for Urgent and Emergency Care for NHS England in December. Professor Redhead visited our Exeter base with a view to providing support to optimise our system control centre.

Professor Redhead was given a tour of the system control centre and spoke with Executive Directors at length about the support that can be offered around optimisation and clinically led system level risk management.

We are grateful to Professor Redhead for taking the time to visit NHS Devon.

In addition, we recently welcomed Berenice Groves and Andrew Cratchley from the NHSE National Team. The purpose of the visit was to discuss ongoing system pressures and the team were also keen to visit the system control centre and see how things are functioning. Anthony Fitzgerald, Nigel Acheson and I spent a few hours with Berenice and Andrew and had a productive conversation.

It has been great to show NHSE the progress that has been made with the system control centre and the ongoing improvement works that have been put in place by our Chief Delivery Officer, Anthony Fitzgerald. A big thank you to him and his team.

Integrated Care System (ICS) executive committee updates

The following are key updates from the ICS executive committee.

Interim Integrated Care Strategy

The Interim Integrated Care Strategy was shared widely with stakeholders before Christmas 2022. Since then, guidance has been received for the development of the five-year Joint Forward Plan (JFP), along with the priorities and operational planning guidance, which must all align. The JFP must respond to the Devon Integrated Care Strategy and the published guidance encourages the systems to make the JFP a true system plan, beyond the NHS. The One Devon Partnership agreed this approach at their Board meeting in January 2023.

The engagement and involvement plan for the JFP is still in development, as is a public-facing version of the Integrated Care Strategy, which will then be socialised with the public.

The format of the JFP will include the four pillars of NHS Devon as well as wider priorities around Housing, Community Development, Employment and Public Health.

Learning and Education Strategy

The Community Upskilling funding of £97,1644.00 from Health Education England was awarded to Devon to support discharge to access and end of life care.
The procurement of education using this fund will provide a strengths-based approach training for champions within community, primary care, and social care staff to aid discharge being scoped. The training is due to start in February 2023 and will take 6 months to a year to fulfil as the training is for 600 members of staff across Devon (500 online sessions and 100 Train the Trainer Champions).

For the end-of-life care, the upskilling aspects is for hospices to upskill their health and social care professionals in advanced communication skills and advanced care planning. The training is being rolled out across the hospices within Devon (Rowcroft, St Lukes, North Devon Hospice).

NHS Devon Integrated Care Board

Devon Workforce Challenges

Date of meeting	Date report produced
15 February 2023	1 February 2023

Author(s)		Report approved by	
Name and title:	Paul Renshaw, Director of Strategic Workforce	**Name and title:**	
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:
N/A

Executive summary
This report is in response to the request from the 19th October 2022 Board meeting. This paper highlights our system wide workforce challenges and summarises our improvement actions. This is a paper that the Board is asked to note. There are not any specific questions being asked of the Board nor any recommendations the Board is asked to make.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
This paper has been reviewed and approved by the People and Culture Committee at the January 2023 Meeting.

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. This is a paper that the Board is asked to note. There are not any specific questions being asked of the Board nor any recommendations the Board is asked to make.

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	**Yes**
Improve services and reduced unwarranted variation	**Yes**
Make more efficient use of our resources	**Yes**
Develop our culture and how we operate	**No**

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	
Health inequalities	
Workforce	Improving the supply and cost of our workforce
Resources and finance	Work is focussed on reducing workforce costs
Legal	
Digital and Data	
Involvement, Engagement and consultation	

NHS Devon Integrated Care Board

Devon Workforce Challenges

February 2023

Contents

1. Introduction

As is the case across all Health and Care Systems, Devon is experiencing multiple challenges across our Health & Care workforce agenda.

The pressure and demands facing our workforce has been relentless since the start of the pandemic and continue in light of significant urgent and emergency care challenges; Covid still being present in our population and the need to reduce our elective care waiting lists at pace.

Our approach to addressing the people challenges is through our One Devon People Plan that has 4 delivery pillars which enable the design and delivery of our system solutions to these challenges, each of which have detailed programs of workstreams to tackle specific workforce issues.

The One Devon People Plan Delivery Pillars are Workforce Strategy & Planning, Learning & Education, Best Place to Work and Workforce Capacity and these align with the National people plan priority areas.

This work is led from the ICB strategic workforce team but is well resourced by colleagues across the system who are responsible for the delivery of these plans within their own organisations as well as contributing to the initial strategies.

As part of our 2023/24 Operational Planning, these programmes of work are being reviewed to ensure that we continue to focus our attention and efforts on addressing the key areas that will deliver maximum benefit for our system partners, our workforce and our Devon population.

The 2023/24 plan will be approved by the Executive Workforce Group and People and Culture Committee in April after which the Board will be updated on the Plan.

The Executive Workforce Group will continue to be where progress of the plan is monitored, with an oversight, challenge and assurance function being carried out by the People and Culture Committee.

2. Recruitment and Retention

Challenges:

- Attracting and retaining staff across the Devon System continues to be a challenge
- Unemployment rates continue to be approximately half the national average (c 13,000 claimants)
- There are currently circa 2000 vacancies (7% vacancy rate) across social care and a turnover rate in excess of 37%

- There are circa 2000 vacancies across health, representing a 5.85% vacancy rate which is in line with national average
- The rolling 12-month average turnover for the NHS is 7.8% compared to SW regional average of 8.8%

Highlights/Actions

- Nursing, AHP and non-clinical vacancies are reducing month on month
- Consultant vacancies remain challenging (106 WTE vacancies) but a dedicated system wide medical recruitment campaign is now live to support recruitment to hard to fill specialties. This approach will be broadened to other medical specialties throughout 23/24
- The system wide international recruitment hub continues to support Health & Care and have placed over 700 nurses in health and are recruiting c175 care workers for social care. This social care campaign was funded by NHS Devon with the first 5 social care colleagues arrived in January. We expect to have completed this exercise by May. Future campaigns will be subject to agreement on where the accountability sits to ensure market sufficiency and any future costs associated with campaigns
- A new approach to social care recruitment via Livewell and PCC has successfully found over 150 new employees for this market, and therefore a business case to have a system wide recruitment approach has been produced and will be considered alongside all other investment plans for the year
- Discussions are underway between health and social care colleagues to agree what activities could be moved from health to social care colleagues under third party delegations from 2023 onwards. The aim is to establish what additional services (for example basic wound care) some social care colleague could deliver, which would enable health colleagues to focus on other activities. This work would also aim to improve attraction and retention in social care
- Retention project in place to focus on nurse retention

3. Agency Expenditure

Challenges

- Dependency on agency staff to help cover vacancies and sickness continues to be high across the System, with a year-end forecast of spending c £44m on agency staff within our Health providers
- Current agency spend equates to 3.3% of overall pay spend - the target for next year is no more than 2.9%

Highlights /Actions

- A new agency framework for Nursing went live in October, reducing the agency margin paid for staff with the AHP and Medical frameworks starting at the end of this financial year

- A collaborative locum Bank for medical roles is now being further developed across Devon to reduce the usage of costly agency locums and replace with directly sourced locum resource at a reduced cost to providers

- All NHS providers have agreed in principle to migrate to an outsourced bank solution for all staff groups during 2023/24 on a phased basis, which will drive £ multi-million savings per annum

4. Health and Wellbeing /Sickness Absence

Challenges

- Staff absence continues to be higher than prior to the pandemic with a rolling NHS 12-month average of c 6.2% for Devon. This rate is higher than the national rolling average of 5.7%

- Staff absence continues to be impacted by Covid and colleague 'burn out 'as well as a recent impact related to seasonal flu

- National funding for Wellbeing Hubs being withdrawn next year

Highlights/actions

- NHS providers have been sharing best practice across the Devon System in supporting colleagues to return to work well with a commitment to colleague's wellbeing

- Proposals currently being reviewed to secure funding for Wellbeing Hub into FY 23/24 from within the system

- Learning from the North west Absence tool to be embedded into sickness absence management protocols, to support staff health and wellbeing and positively impact sickness absence rates. Deep dive review on absence will take place at the People and Culture Committee in May 2023

5. Workforce Strategy and Planning

Challenge

We do not have a workforce strategy that describes the required size and shape of the workforce for the future with associated learning and education plans and do not have access to any useful workforce planning tool

Highlight /action

- Draft narrative strategy will come to People and Culture committee in February and ICB Board in March. This is required for inclusion in our Joint Forward Plan. This narrative strategy is being produced in a way that ensures that future service redesigns are carried out in a such a way that workforce can be found and can be afforded and sets ambitions around growing more local talent. The national workforce strategy is due to be published in the spring at which point we will need to revisit our strategy

- A costed workforce plan following agreement of our workforce and financial strategies will be completed by end of Q1 2023/24

- We are building a strategic workforce planning modelling tool in collaboration with Health Education England. This will be launched for use as a beta version in Q1/Q2 2023/24 and is intended for use across health and social care. Once we have fully implemented, this will be shared with Regional/ National colleagues since at present there is no nationally mandated tool or methodology in the NHS.

NHS Devon

NHS Devon Integrated Care Board

Torbay Special Educational Needs and Disability (SEND) Strategy

Date of committee	Date report produced
15 February 2021	27 January 2023

Author(s)		Report approved by	
Name and title:	Torbay SEND Family Voice	**Name and title:**	Darryn Allcorn Chief Nursing Officer
Phone:		**Date:**	27 January 2023
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary
A co-designed strategy has been developed in Torbay as part of the Written Statement of Action and there is a request for each Partner agency to acknowledge and support the Strategy within their respective Boards. We know we must do better when it comes to delivering services for children and young people with Special Educational Needs and Disabilities (SEND), and their families – and we are firmly committed to doing so. Placing children, young people, and their families at the heart of this work is key to achieving this and the principles of co-design and co-production will underpin everything we do.

One Devon

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Partners across the local area in Torbay are committed to working in partnership with SEND Family Voice Torbay as well as children, young people, parents, carers, and partner organisations to radically improve support for children and young people with special educational needs and/or disabilities within Torbay so they have the very best life chances.

This SEND Strategy sets out our ambitions and the priorities upon which we will focus to achieve them. As we measure our progress against our priorities, we will continually ask ourselves, as well as our children and young people, and their parents and carers, "what difference have we made?"

Committees that have previously discussed/agreed the report, and outcomes of that discussion

The Torbay SEND Improvement Board have approved the Strategy and shred with regulators including OFSTED and CQC with a recommendation to endorse as the Integrated Care Board

The strategy was produced together with key partners and draws upon the following information:

- Feedback from children, young people, and their parents/carers
- Feedback from professionals and front-line workers
- Feedback from education settings
- Data from health, social care, and other key agencies through our Joint Strategic Needs Assessment (JSNA)
- SEND peer review (2021)
- Torbay local area SEND inspection and subsequent Written Statement of Action
- Participation Survey (2022)

This strategy covers the key areas that will help us to make cultural change, keep up momentum and be more responsive to the need across our local area. The strategy cannot be considered in isolation and acknowledges that there are interdependencies with the development of Family Hubs, Child Friendly Torbay, and the development of the Integrated Care System for Devon.

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do

1. Consider the Strategy and recommendations made in order to endorse as an Integrated Care Board.

Impact on NHS Devon objectives

Objective	Impact
Improve population health	**Positive**
Improve services and reduced unwarranted variation	**Positive**

Make more efficient use of our resources	**Positive**
Develop our culture and how we operate	**Positive**

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	Through a clear collective strategy that focuses services around the young person will enhance the quality of services across multiple agencies.
Health inequalities	Effective support of young people will address inequalities identified within the JSNA
Workforce	The Strategy will require teams to work differently and across VCSE and statutory partners
Resources and finance	No implications on finance
Legal	
Digital and Data	
Involvement, Engagement and consultation	The strategy has been co-developed and owned by the family voice in Torbay

Torbay SEND Strategy

2022

TORBAY COUNCIL

Contents

Foreword – DRAFT TO BE APPROVED

Torbay's Joint Health and Wellbeing Strategy sets out a vision 'to create a healthy, happy Torbay where individuals and communities can thrive'.

Children and young people are our future and our ambition of achieving this vision must start with them. Getting a good start in life and childhood, building resilience and getting maximum benefit from education are important markers for good health and wellbeing throughout life. Offering support to all children, young people and their families, as well as focusing on those who need help the most, reduces inequalities and improves health outcomes.

We know we must do better when it comes to delivering services for children and young people with Special Educational Needs and Disabilities (SEND), and their families – and we are firmly committed to doing so. Placing children, young people, and their families at the heart of this work is key to achieving this and the principles of co-design and co-production will underpin everything we do.

Partners across the local area in Torbay are committed to working in partnership with SEND Family Voice Torbay as well as children, young people, parents, carers and partner organisations to radically improve support for children and young people with special educational needs and/or disabilities within Torbay so they have the very best life chances.

This SEND Strategy sets out our ambitions and the priorities upon which we will focus to achieve them. As we measure our progress against our priorities, we will continually ask ourselves, as well as our children and young people, and their parents and carers, "what difference have we made?"

We are committed to:

- Working determinedly for a child friendly Torbay where children and young people with SEND and their families experience a well-planned continuum of provision from birth to 25 and beyond.
- Aiming high so that all children and young people with special educational needs and disabilities are able to reach their full potential, receive the right support, at the right time, with choice and control so that they can lead fulfilling lives.
- Aligning our resources to drive sustained improvement.

We are determined to work together to ensure an improvement in the quality of outcomes for those children and young people with special educational needs and/or disabilities.

Councillor Cordelia Law
Cabinet Member for
Children's Services
Torbay Council

Darryn Allcorn
Chief Nursing Officer
NHS Devon

Rebecca Box
Chair
SEND Family Voice Torbay

Introduction

This strategy sets out a vision and direction of travel for children and young people,0 – 25 years, with Special Educational Needs and Disabilities (SEND) in Torbay. It is intended to cover the 'local area' of Torbay and can only be achieved through effective partnership between children, young people, parent and carers and our local system; the local authority, Integrated Care System (ICS) (health), public health, NHS England for specialist services, early years settings, schools, further education provisions and the voluntary and community sector.

The legal definitions outlined in the Equality Act 2010, Children and Families Act 2014 and SEND Code of Practice 2015 are used in this strategy to provide our framework for delivery and identify what we mean by children and young people with SEND.

This strategy has been produced in partnership and represents a marked shift in our local area. It builds upon the current lived experience and expertise of our children, young people and their parents/carers and sets out an ambitious goal for making sure that SEND becomes 'everybody's business' through pro-active inclusion, improving the experience at every opportunity.

The strategy was produced together with key partners and draws upon the following information:

- Feedback from children, young people and their parents/carers
- Feedback from professionals and front-line workers
- Feedback from education settings
- Data from health, social care and other key agencies through our Joint Strategic Needs Assessment (JSNA)
- SEND peer review (2021)
- Torbay local area SEND inspection and subsequent Written Statement of Action
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This strategy covers the key areas that will help us to make cultural change, keep up momentumand be more responsive to the need across our local area. The strategy cannot be considered in isolation and acknowledges that there are interdependencies with the development of Family Hubs, Child Friendly Torbay and the development of the Integrated Care System for Devon.

A Shared Vision

The shared vision for the strategy was produced with representatives from across the local area. The shared vision is:

- **SEND is everybody's business** - embedding the vision and values into the practice of everyone who works with children and families from 0-25 years.
- **Identify and respond to needs early** - in ways that value lived experience and expertise, offering personalised care and support.
- **Deliver in the right place at the right time** - always asking 'so what difference are we making in the life of this child or young person?'

Our vision will be delivered through five priority areas:

- Priority 1: SEND is everyone's business - embedding our values through education, health and social care, changing culture and reforming our workforce.
- Priority 2: Identify and act on children's needs at the earliest opportunity, through valuing lived experience and expertise.
- Priority 3: Understand the needs of our children, young people and families and make sure joint commissioning supports service delivery and we make best use of all resources
- Priority 4: Make sure that all early years providers and mainstream educational settings support an inclusive approach to education
- Priority 5: Improve transition planning for young people moving into adulthood.

To achieve this vision, young people, parents, carers, professionals and services across the local area have agreed to adopt a set of principles that have been set out in a partnership pledge. We know that the success of our strategy depends on cultural change.. The commitments that we expect everyone to adopt and sign up to have been defined by our children and young people.

Our Pledge

- **Be honest**
  We will tell you the truth, we will listen and work with you to plan and explain what is possible and why things may need to change or happen
- **Show you we care**
  We will listen carefully and make sure that we build a plan of support around your aspirations, hopes and goals
- **Be thoughtful**
  We will treat you as the expert, build our professional knowledge of your needs and what is available to help you
- **Be fair**
  We will treat you and your family with respect
- **Be kind**
  We will listen carefully and ask you how you want to receive your support

- **Be friendly**
  We will take time to find out lots about you, we will celebrate with you when things go well and help you when things are difficult

Restorative Practice

We will underpin our strategy by continuing to adopt Restorative Practice. Restorative Practice is about putting strong, meaningful and trusting relationships at the heart of how we work with children and families. It means we will offer supportive relationships combined with clear goals that are focussed on the needs of children. It also places emphasis on family led decision making to how we solve problems. Our strategy is underpinned by the principles of listening and working "with" rather than doing things "for" or "to"..

Our Statement of Commitment

We are committed to working with children and young people with Special Educational Needs and/or Disabilities and their families.

- We commit to working together, in partnership with you, to improve the support you receive. We want you to have the very best opportunities now and in the future.
- We will make sure you are able to have your say in what happens to you, in a way that suits you. We will value what you say.
- We will use what you tell us to help us make plans and decisions, as well as in our day-to-day work.
- We want to work with as many local people, groups, organisations and experts as possible to make our services the best they can be. We will do our best to not leave anyone out.
- We know we might not get it right every time, but we will learn from our mistakes and improve as we go along.

Priority 1: SEND is everyone's business – embedding our values through education, health and social care, changing culture and reforming our workforce

Children and young people have told us what they would like to see for this priority:

"SEND needs should be treated as equally important across all areas and services"

1.1 What have children, young people and families told us about this priority area?

- "We have to fight/battle to get what we need".
- "Not all professionals understand enough or feel confident enough to make children, young people and families feel safe and heard".
- "There are a lot of unmet promises and people are not always honest".
- "It can be difficult to be believed".
- "The processes are complicated, there is built in jargon, and it can be hard to understand".

1.2 Why is this a priority?

Changing culture is at the heart of providing high quality services across the local area. Experiencing positive values, behaviours and responses is essential to be able to identify need, provide support and high quality responses for our children and young people with SEND and their families. For everybody working with or providing support to children and young people, interaction matters and can set the trajectory of travel for the young person. If this is conducted with a biased opinion, without good knowledge, or through misguided information it can lead to further concern and distress.

"Culture" can seem like an ambiguous term; how is it valued or is it measured? It is hard to quantify, but if it is not right, the result is can be a poor lived experience. One of the definitions of culture is: "It's the stories we tell ourselves about ourselves" and the stories are based on our experiences based on our behaviours. Our strategy wants to bring consistency and change to the habits and behaviours of everyone that is involved in SEND. We want our different behaviours and habits to lead to different stories.

1.3 How will we implement this?

- We will create, develop and promote a shared expectation of responsibility across all our service providers who come into contact with children and young people with SEND.
- We will make sure that working together (co-production) is at the heart of our practice, always striving to work together from the outset.

- We will make sure that every service is signed up to the SEND pledge and hold each other to account on the experiences that are received by children, young people and families.
- Each organisation will have oversight and responsibility for implementing the pledge and for undertaking all that is needed is in place to make sure that at every level the values are delivered.
- We will make sure that we develop our workforce to build knowledge, skills and shared practice. We will make sure that this is -created with parents and carers and, where possible, we will facilitate shared training opportunities.
- We will make sure that our systems and processes are further aligned, reviewing how we share information, produce meaningful content and hold people to account on its delivery.
- We will deliver and embed a rigorous quality assurance framework, learning from what works well and seeking evidence of how things can be improved.

1.4 What will children, young people and their families see?

- Children, young people, parents and carers will report increased confidence in their experiences.
- Our annual participation survey will show evidence of year-on-year improvements, demonstrating a change in the lived experience of the system and professionals.
- All partners will know the Local Offer and what the contribution of their service and other services should be.
- Children, young people, parents and carers will know how to seek support and can navigate the system with greater understanding and ease.

Priority 2: Identify and act on children's needs at the earliest opportunity, through valuing lived experience and expertise

Children have told us what they would like to see for this priority:

"Treat all young people as a priority, not just those that have the highest needs"

2.1 What have children, young people and families told us about this priority area?

- "We want to be listened to and heard; we don't want to have to repeat our story again and again"
- "You have made promises to us that haven't been kept"
- "We have to battle for our children, to get them what they need"
- "We want you to be honest with us"
- "We know our children and understand that their needs change as they get older"
- "We want to be treated with respect"

2.2 Why is this a priority?

A child's life is full of opportunities to learn and develop, to foster a whole set of personal strengths and skills that will prepare them for their life ahead. When we work together with families, we can provide the right conditions to maximise these opportunities through:

- Preventing problems from occurring
- Identifying problems and challenges early
- Tackling things head on before problems become worse

"While some have argued that early intervention may have its strongest impact when offered during the first few years of life, the best evidence shows that effective interventions can improve children's life chances at any point during childhood and adolescence." (Early Intervention Foundation)

For children, young people and parents and carers this means valuing their lived experience and expertise. This matters because it is only those who have had direct experience who will truly understand the nuances and complexities of that experience and what it will mean for their lives.

2.3 How will we implement this?

- Each organisation will have oversight and responsibility for making sure that lived experience and expertise is the 'Golden Thread' running through all workforce

development plans so that children and families are valued as partners in care and support.

- We will promote an inclusive, timely and graduated response to improve confidence, capacity and trust in local support.
- We will make sure that everyone is able to identify and respond to needs early, from pre-birth to 25 years, from the earliest point of contact, for example, including health visitors, midwifery, hospital staff, GP and early years.
- We will achieve a consistent and cohesive Local Offer of early support through family hubs, schools and settings voluntary and community sector that is easy to understand
- We make sure that all organisations and services measure the outcomes of their work with families and capture this so that there is continuous improvement in the way services are delivered to meet need.

2.4 What will children, young people and their families see?

- Children, young people, parents and carers will feel listened to and heard within the local area.
- Staff in early help services, schools and settings will feel confident about their role in providing support early and in identifying when a child or young person has needs ~~that~~ which extend beyond ~~there~~ their scope of practice
- Young people, parents and carers and workers across the local area will know how to get support at for all levels of need.
- Children, young people, parents and carers will report that they feel like partners in the decisions made about their support plans, including the choices available and any limitations in that choice.
- As a local area, we will be able to understand how well outcomes for children and young people are being improved and how thigs might need to change to make a greater impact.

Priority 3: Understand the needs of our children, young people and families and make sure joint commissioning supports service delivery and we make best use of all resources

Children have told us what they would like to see for this priority:

"We are stronger together"

3.1 What have children, young people and families told us about this priority area?

- "Professionals are working in silos"
- "Navigating the system is confusing"
- "Please recognise we grow and change – build on our strengths"
- "Don't underestimate me"
- "The 'system' is built around professionals not the child"

3.2 Why is this a priority?

The SEND Review: Right support Right place Right time (DFE, March 2022) sets out a robust case for a change in the way we understand our population needs and commission services to meet them:

> "We are clear that, in an effective and sustainable SEND system that delivers great outcomes for children and young people, the vast majority of children and young people should be able to access the support they need to thrive without the need for an Education Health and Care Plan (EHCP) or a specialist or alternative provision place. This is because their needs would be identified promptly, and appropriate support would be put in place at the earliest opportunity before needs can escalate. Those children and young people who require an EHCP or specialist placement would be able to access it with minimal bureaucracy. To shift the dial, we are setting out proposals for an inclusive system, starting with improved mainstream provision that is built on early and accurate identification of needs, high-quality teaching of a knowledge-rich curriculum, and prompt access to targeted support where it is needed. Alongside that, we need a strong specialist sector that has a clear purpose to support those children and young people with more complex needs who require specialist or alternative provision. We need a system where decision-making is based on the needs of children and young people, not on location. This must be underpinned by strong co-production and accountability at every level, and improved data collection to give a timely picture of how the system is performing so that issues can be addressed promptly.

"The Review has heard the need to align system incentives and accountabilities to reduce perverse behaviours that drive poor outcomes and high costs in the current system. Where local systems work more effectively, they are often too reliant on good will and relationships and this is the exception rather than the norm. We need every partner to be clear on their responsibilities in the system, have the right incentives and levers to fulfil those responsibilities and be held accountable for their role in delivery."

3.3 How will we implement this?

- We will understand the needs of our children and families by always listening to them and using information and data in the best way.
- Together we will decide our commissioning priorities and deliver our joint commissioning strategy.
- We will work with all services throughout our local area to make the best of the resources for our children and young people to be supported locally.
- We will make sure families feel confident that there is a good and an appropriate local choice option for children and young people in all but the most exceptional cases
- We will address the issues arising from the growth in demand and population, particularly the 16 years plus age group
- We will focus all local resources (health, education and social care) to improve the total provision so that children and young people can be supported locally
- We will review and re-model our resources so that they are sufficient to meet current and future need
- We will work together to make sure best value is achieved for our public resources.

3.4 What will children, young people and their families see?

- A dynamic and live Joint Strategic Needs Assessment (JSNA) will support our commissioning, transformation and resource management.
- Families will be able to access support earlier preventing problems from becoming worse and resulting in higher levels of need.
- Families will be involved in the co-design of new services and in the reshaping of resources.
- Budgets across education, health and care will be understood by the local area to enable and inform the reshaping of resources.
- There will be a reduction in the higher needs block spend.

Priority 4: Make sure that all early years providers and mainstream educational settings support an inclusive approach to education

Children have told us what they would like to see for this priority:

"Give opportunities to attend relevant training to support with SEND needs"

4.1 What have children, young people and families told us about this priority area?

- "We feel underestimated and not understood."
- "There is inconsistency, what you can get from one school isn't available another school."
- "You are not always told the truth; some adults really care but others do not show this."
- "My school changes things all of the time and it is hard to understand this."
- "Professionals are not always transparent about the plans in place for me."
- "We want people to be fair and not always think we are in the wrong."
- "I am not able speak to the appropriate person to discuss my child or young person."

4.2 Why is this a priority?

In a disjointed setting of schools and education provision, there is an inconsistency in our ability to meet children and young people's needs. The school system is independent in decision making and where good practice emerges this may not be repeated across the system. The experience of children and young people with SEND is variable.

Experiences of Torbay's families are aligned with the SEND Green Paper March 2022.

> "It is not clear to families what they should reasonably expect from their local mainstream settings, and they lose confidence that these settings can meet their child's needs. As a result, education health and care plans (EHCPs) and, in some cases, specialist provision, are seen as the only means of guaranteeing the right and appropriate support". (SEND Green Paper 2022)

For many children with SEND they have poor attendance, are subject to repeated suspensions and are more likely to get excluded from a Torbay school than when compared to statistical and national comparators. For some schools excellent practice exists where needs are identified at SEN K and support is offered consistently and with impact, for others there is an over reliance on the need for Education Health and Care Plans to meet needs.

For the vast majority of our children and young people with SEND, access to education should be provided through mainstream education, our schools and colleges, with high quality identified support. Specialist and alternative provisions should be retained for those with clearly identified and complex needs.

Excellent teaching is the bedrock of strong mainstream provision. Research from the Education Endowment Foundation (EEF) found that teacher strategies, additional teaching and positive interactions with teachers are important factors for improving the outcomes of children and young people with SEND.

4.3 How will we implement this?

- We will rewrite our response and make sure that this is delivered consistently across all education provisions.
- We will help with the joint commissioning of services within school networks, to support the creation of equal resources and opportunities.
- We will set up a clear inclusion framework and dashboard, recognising good practice and addressing less inclusive practice.
- We will establish a workforce development programme that will make sure that all education provisions become attachment and trauma informed institutions
- We will build the confidence of our teachers to be able to meet needs in the classroom. We will make sure that schools have accredited training through the Autism Education Trust and Speech and Language UK organisations.
- We will use our family hubs to make sure that education practitioners are able to work with professionals at a prevention level, helping to unlock specialist advice and support at an early opportunity.
- We will deliver additional enhanced resource bases for children and young people with social emotional and mental health needs based within mainstream education.
- We will use our SEND capital money to make sure that we are driving mainstream inclusion, providing schools with vital resources to make necessary changes and adaptions.
- We will set out and deliver an agreed strategy for reducing suspensions and exclusions.
- We will reduce the reliance on an Education Health and Care Plans to be able to meet need, improving confidence in educational settings to support children and young people at SEN K, in time freeing up resources to be used differently.
- We will deliver our new attendance strategy, which will support SEND learners.

4.4 What will children, young people and their families see?

- Children and young people with SEND will report that they feel supported and can trust the adults around them.
- Children and young people with SEND will be taught predominately in mainstream education alongside their peers.
- Children and young people with SEND will have high attendance rates.

- Children and young people with SEND will have reduced suspensions and exclusions year on year.
- Provision across the education system will demonstrate a greater inclusive practice, equality of opportunity and consistency.

Priority 5: Improve transition planning for young people moving into adulthood

Children have told us what they would like to see for this priority:

" We want to increase the services and awareness of what services are available for supporting young adults.

5.1 What have children, young people and families told us about this priority area?

- "We change and get older, so it will be our choices and our ideas, not our parents."
- "We want to be listened to; my perspective of my needs may not be the same as others."
- "I need to know what is happening and what changes will take place for me."
- "I feel I face a cliff edge at 18."
- "There is not enough choice in the provision that is available to me as I get older."

5.2 Why is this a priority?

The tragic fact is that on all indicators, people with disability fare much worse than their peers in the general population. However, research has shown that young people with SEND say they want the same opportunities as all young people, so that they could have the same life outcomes. This includes:

- Paid employment and access to higher education
- Housing options and independent living
- Good health
- Friends, relationships, community inclusion
- Choice and control over their lives and support

(Source: Council for Disabled Children)

Young people will need our support and encouragement to get ready for the challenges and increased independence of adult life. They need us to help plan ahead, providing opportunities to share aspirations and hopes and building meaningful and well produced plans that can become a reality over a period of time. Professionals need to know what part they play in helping to plan for the future and have confidence and knowledge of the system to make sure that this can be delivered and maintained into adulthood.

For young people and their families, preparation for adulthood should be well planned and understood. For many young people there will be a marked change to greater independence, however for some young people there needs to be a continuum of provision. We need to make sure that moving between children's social care services to adult social care services is a seamless process.

5.3 How will we implement this?

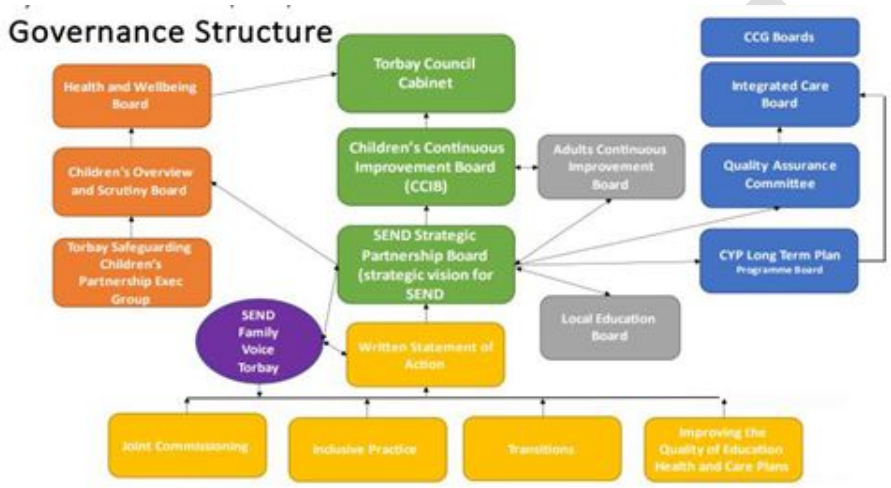
- We will deliver our strategy for multi-agency working from year 9. This includes a protocol for professionals to work together, including when and how the Care Act transition assessment will take place and how support and provision contributes to the achievement and development of outcomes.
- We will make sure that our Education Health and Care Plans include co-produced, preparing for adulthood outcomes in section E and there is evidence of a alignment from aspirations to outcomes.
- We will make sure that our Local Offer has a comprehensive range of options that enable young people and their carers to know what is available locally.
- We will make sure that our commissioned services are mapped, gaps are identified and post 16 is delivered as a commissioning priority.
- We will make sure that all young people with SEND from the age of 16 are on study programmes, this includes work experience.
- We will make sure that across the partnership organisations we directly offer pathways to work experience and employment for young people with SEND.
- We will promote and offer personal budgets.

5.4 What will children, young people and their families see?

- Our young people will experience a transition to adulthood that enables them to achieve their aspirations and goals.
- Our young people will tell us they have choice and feel well supported.
- There will be detailed Preparing for Adulthood outcomes in place for all young people.
- Young people will talk confidently about the future and be able to articulate the agreed plan.

Who will oversee the strategy?

We will have robust governance in place to make sure we deliver our commitment to improved services for children and young people with SEND and their families. The SEND Strategic Board, which includes representatives from SEND Family Voice, Department for Education , NHS England Advisors, reports into our Children's Continuous Improvement Board (CCIB) making sure that our work around SEND is embedded in a broader approach to improvement and securing the very best outcomes for children and young people with SEND.



Appendices <to add>

Glossary <to add>

This document can be made available in other languages and formats.

For more information, please contact **insert your team email or phone no here**

NHS Devon

NHS Devon Integrated Care Board

Urgent and Emergency Care Recovery Plan

Date of committee	Date report produced
15 February 2023	8 February 2023

Author(s)		Report approved by	
Name and title:	Anthony Fitzgerald Chief Delivery Officer	**Name and title:**	
Phone:	07515 359466	**Date:**	
Email:	Anthony.fitzgerald8@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary
Urgent and Elective Care Recovery Plan – NHS Improvement paper. The operational planning guidance (Dec 2022) outlined 3 key priorities linked to a shorter List of performance metrics. For urgent and emergency care (UEC) these will focus on: • Recovery of core services and productivity levels • Delivery of key long term plan ambitions • Transforming the NHS for the future through local empowerment and accountability

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Key recommendations and actions requested – please be explicit on what you are asking the committee/board to do
1. For information; with developed Recovery Plans to be submitted via Board Sub-Committees

Impact on NHS Devon objectives	
Objective	**Impact**
Improve population health	Delivery against constitutional standards. i.e., 4-hour ED standard and reduction in ambulance waits.
Improve services and reduced unwarranted variation	Delivery against constitutional standards. i.e., 4-hour ED standard and reduction in ambulance waits.
Make more efficient use of our resources	Delivery against constitutional standards. i.e., 4-hour ED standard and reduction in ambulance waits.
Develop our culture and how we operate	

Outline the implications of matters covered in this report for the following areas (if none, please state)	
Area	
Quality of services	Will require changes in resource allocation and workforce development. These are specific sections for consideration and development within the overall NHS Devon plan.
Health inequalities	none
Workforce	none
Resources and finance	none
Legal	none
Digital and Data	none
Involvement, Engagement and consultation	none

NHS DEVON - IMPROVING URGENT & EMERGENCY CARE

1 INTRODUCTION

1.1 The operational planning guidance (Dec 2022) outlined 3 key priorities linked to a longer list of performance metrics (see below). For urgent and emergency care (UEC) these will focus on:

- Recovery of core services and productivity levels
- Delivery of key long term plan ambitions
- Transforming the NHS for the future through local empowerment and accountability

FIG 1 - PERFORMANCE METRICS, OPERATIONAL PLANNING GUIDANCE

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

2 URGENT CARE IMPROVEMENT

2.1 On 30 January 2023, NHS England published the joint NHS and DHSC Delivery Plan for Recovering Urgent and Emergency Care Services. The key deliverables for the next two years will focus on improving patient flow to improve UEC performance. This will be measured through a 30-minute mean response time for Category 2 ambulance and 76% performance in A&E wait times.

FIG 2 - PLANNING FOR IMPROVEMENT MILESTONES

Date	Milestone
23 December 2023	Key planning guidance documents published or shared in draft form
January 2023	Technical guidance, templates and tools issued
30 January 2023	Collection portal and functional templates available
By end January 2023	Publication of UEC Recovery Plan
6 February 2023	Publication Demand and Capacity and Ambulance templates
15 February 2023	**Completion of proposed Ambulance Capacity expansion plans (SWAST with Lead Commissioner sign off)**
23 February 2023 (noon)	**Submission deadline- draft operational plans. 1st cut Demand and Capacity Plans**
By end February 2023	Publication of Primary Care Recovery Plan
During March	Review of Ambulance and Bed Demand and Capacity Plans and confirmation of funding allocations
By March 2023	Final NHS standard contract and 2023/25 payment scheme published (both subject to consultation)
30 March 2023 (noon)	**Submission deadline- final operational plans, final Demand and Capacity and Ambulance plans**
By no later than 31 March 2023	Contracts agreed and signed
By 31 March 2023	Draft Joint Forward Plans produced
By 30 June 2023	Final Joint Forward Plans published

2.2 The plan requires joint working across health and care, to ensure patients get the best care and to ensure patient flow through hospitals and into social care when needed, and it sets out actions in the following areas:

- **Increasing capacity** – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow.
- **Growing the workforce** – increasing the size of the workforce and supporting staff to work flexibly for patients.
- **Improving discharge** – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter.
- **Expanding and better joining up health and care outside hospital** –stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.
- **Making it easier to access the right care** – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

3 INCREASING CAPACITY

ADDITIONAL HOSPITAL BED CAPACITY

3.1 Compared to the 2022/23 plan, there will be 5,000 more beds across the NHS in 2023/24. To ensure that this additional capacity is distributed equitably and sustainably, systems are asked to undertake demand and supply profiling by April 2023 to identify areas with the greatest need.

3.2 Systems are expected by April 2023, to conduct appropriate demand and capacity profiling to identify the areas with the greatest need. The results of this profiling will be used to ensure that any increase is aligned with other capacity such as staffing and diagnostics

3.3 Local systems will be expected to maximise the use of existing estate, where possible. Systems should also make use of modular buildings where possible, building on the additional funding announced this year, given that they provide flexible capacity and can be brought on stream relatively quickly. The additional bed capacity will also better protect beds and other spaces for planned care, including those being delivered through NHS England's Targeted Investment Fund.

INCREASING AMBULANCE CAPACITY

3.4 According to NHSE's analysis, handover delays are not the only cause of slower ambulance response times. Increases in staff sickness absence is also a key factor, while an increasing complexity of workload means incidents take longer. As such, increasing ambulance capacity is seen as a key to reducing waiting times. To deliver this, NHSE is asking ambulance services and lead commissioners.

3.5 Determine their capacity plans for 2023/24 by March 2023 and identify gaps, including looking at ways to reduce sickness absence.

3.6 NHSE will also work with ambulance services and systems to increase capacity by putting in place consistent access to clinical advice, implementing a single point of access for paramedics to get advice from qualified clinicians to ensure patients are referred to the most appropriate services and unnecessary conveyances are cut.

3.7 By Autumn 2023, NHSE plans to increase clinical assessment of calls in ambulance control centres. Work will also continue to develop the "Intelligent Routing Platform" to manage the distribution of calls across England when individual services come under greater pressure.

3.8 In line with the Long-Term Plan, NHSE also plans to increase mental health expertise in ambulance services. This will include ensuring that mental health professionals are embedded in emergency operations centres ahead of winter 2023/24.

4 INCREASE WORKFORCE SIZE AND FLEXIBILITY

4.1 As part of the plan, NHSE plans to help staff by growing the workforce including a focus on new roles, freeing up staff from the unnecessary burdens which they face in their day-to-day work, and allowing staff to work more flexibly. A full long-term workforce plan will be published this year, as such NHSE can only set out limited actions to support and grow parts of the workforce in the short term.

4.2 Specific actions include:

- From April 2023 NHSE will launch a promotion campaign for working in NHS 111 and integrated urgent care.
- Projected paramedic workforce gaps will be mitigated through undergraduate student intake. A focussed retention improvement plan will also be developed in agreement with ambulance services as part of the current planning process.
- Emergency medical technician numbers will be increased over 2023/24 as part of the plan to grow ambulance sector capacity.
- Increasing the numbers of advanced practitioners in priority areas including in emergency care.

4.3 There are plans to continue the expansion of the mental health workforce within UEC. This includes clinical roles, such as ambulance mental health workers staffing specialist new vehicles.

4.4 NHSE is asking systems as part of the 2023/24 planning round to develop and implement integrated UEC workforce plans based on capacity and demand assessments in line with local population need. These plans will need to consider wider out-of-hospital services, including community services such as rehabilitation, therapy and reablement, and community nursing.

4.5 To scale virtual wards, NHSE will develop a national workforce recruitment capacity and capability plan. This plan will include multi-disciplinary teams, including with training in frailty, access to specialist and consultant oversight required to deliver hospital level care at home, and the therapy workforce.

4.6 Work is also underway with the Home Office to allow greater flexibility for overseas workers and make the visa sponsorship system more straight forward.

5 IMPROVING DISCHARGE

5.1 NHS sets out its view that to improve discharge there must be an increase in capacity in step-down services (‘intermediate care') and social care, especially domiciliary care. This requires sustained long-term investment, in the social care workforce given the scale of vacancies in the sector. Plans to improve discharge sit across three areas, each with specific actions:

SCALING UP INTERMEDIATE CARE

5.2 Six new ‘national discharge frontrunners’ have been announced, of which three will focus on intermediate care. NHSE is also doing intensive work with two additional sites to test innovative approaches to intermediate care, including reablement and wrap-around care. By autumn 2023, NHSE will develop a new planning framework and national standard for rapid discharge into intermediate care, building on the learning from the frontrunner sites

SCALING UP SOCIAL CARE

5.3 At the Autumn Statement 2022, the government made available up to £2.8 billion in 2023/24 and £4.7 billion in 2024/25 of additional funding to support an increase in capacity and improve the quality of and access to care. The government will set out further details as part of the Local Government Finance Settlement and guidance to local authorities in February, but a key focus will be to increase capacity in social care.

IMPROVING PROCESSES AND STANDARDISING CARE

5.4 Reducing variation in care when patients arrive at A&E and ensuring greater consistency in referrals to specialist care, and access to same day emergency care (SDEC) so patients avoid unnecessary overnight stays is a core priority. Embedding system control centres and implementing new response times for urgent mental health care are also seen as key to improving experience and balancing clinical risk at a population level. To achieve this, NHSE will put in place the following:

5.5 By April 2023, there will be a new "improvement programme" in place to support standardisations.

5.6 Working with systems, NHSE will work to spread best practice in ensuring SDEC services are more resilient next winter and that SDEC capacity is not diverted to other emergency care provision.

5.7 A new frailty Commissioning for Quality and Innovation (CQUIN) incentive will support delivery of frailty services and link funding to quality improvement.

5.8 System control centres will become year-round. Systems will work with local authorities and other partners to ensure capacity, including in care providers, is used effectively and that the NHS provides support where needed.

5.9 Trusts are expected to have electronic bed management capabilities by summer 2023 and NHSE will support all trusts to have implemented appropriate solutions by the end of the year. NHSE will also continue to develop and roll out the A&E admissions forecasting tool.

6 EXPANDING AND BETTER JOINING UP HEALTH AND CARE OUTSIDE HOSPITAL

6.1 NHSE have outlined some opportunities presented through the recovery of UEC services, though:

- Improving urgent and community response times, consistently meeting or exceeding reaching 70% of patients within two hours by next winter. Continuing roll out will be achieved through national support and targeted funding, meaning an increase in referrals to UCR in winter 2023/24 and an increase in transfer of patients from ambulance to community services.
- The NHS will roll out adult and paediatric acute respiratory infection (ARI) hubs to provide timely access to same day urgent assessment, preventing hospital attendance and ambulance conveyances.
- Expanding community mental health services and building on the recent expansion of community-based crisis services to ensure that all systems have a range of open-access age-appropriate services which meet local population needs, alongside 24/7 crisis resolution and home treatment provision.
- Systems will continue to roll out high intensity user services, adopt good practice in supporting patients who are experiencing homelessness or rough sleeping, and embedding family support workers in A&E settings to provide additional support to children and families presenting with non-urgent issues.

EXPANDING VIRTUAL WARDS

6.2 NHSE is currently developing virtual wards at scale through investment in community provision for conditions including frailty, acute respiratory conditions, and heart failure. 7,000 virtual beds have already been rolled out, and the plan is to scale up capacity to above 10,000 by next winter. Utilisation of virtual wards should increase from 65% to 80% by September 2023. In the longer term, as advances are made in 'point of care' diagnostics and remote monitoring, virtual wards will be a standard alternative to acute care in hospital across a range of conditions.

6.3 The NHS will scale up virtual ward capacity for frailty and acute respiratory infection, building on the evidence of what has worked well this year, to make sure that the offer exists for patients across the country. Local areas have developed plans to deliver at scale. We will continue to work with clinical communities to drive growth in virtual ward admissions

6.4 Building on experience from GIRFT, NHS England will work with systems to establish a data-driven approach to peer review that supports implementation. National and regional support will be provided through tools and resources to enable service review, clinical audit and approaches to diagnostics and tech enable

6.5 NHS England will support systems to implement new models of virtual wards, in more clinical areas, including for patients with a broader range of conditions. Clinical advice on which areas are most appropriate for this expansion is currently being developed and clinically led guidance and guidelines will be put in place to allow people to scale ahead of winter for priority pathways including heart failure and paediatrics

6.6 NHSE will support systems to build on the expansion of Home Treatment teams for people with acute mental health needs, with a focus on the quality of provision and therapeutic offer, underpinned by technology and data to better manage and plan care to avoid deterioration and unnecessary hospital admission.

6.7 The central ambition here is make it easier for patients to access care without feeling they must go to A&E or call 999. To help achieve this NHSE expect to undertake the following:

- Expand advice offered through nhs.uk and NHS 111 online to provide dedicated paediatric advice and guidance for families to support decision making around care options.
- Undertake a review of 111 services, including trials of 111 First. The review will also explore the potential to incorporate advancements in technology, including AI and machine learning, within 111 services.
- ICBs will also be asked during 2023/24 to commission the clinical assessment of a greater proportion of NHS 111 category 3 or 4 ambulance dispositions.

7 DEVELOPING THE PLAN

7.1 The recovery plan is intended to set out a framework for systems to deliver improvements. Delivery will align with the NHS operating framework and ICBs will be accountable for improving the core performance standards.

7.2 ICBs are expected to work with partners, including trusts, to agree plans to achieve recovery in the next two years.

7.3 ICBs and local authorities should also work with providers to undertake systematic capacity and demand planning, with the aim of understanding the expected levels of need for social care and intermediate care services in their local area and developing shared plans to meet this need.

FIG 3 - IMPROVEMENT DELIVERY LEADS

Section	ICB Lead	Provider Leads
Increasing capacity • Additional hospital bed capacity • Increasing ambulance capacity • Improving processes and standardising care	CDO - CMO	COO Ambulance Service and Lead Commissioner CMO
Growing the workforce	ICS Director of Workforce	COO
Improving discharge	Strategic Discharge Lead	COO

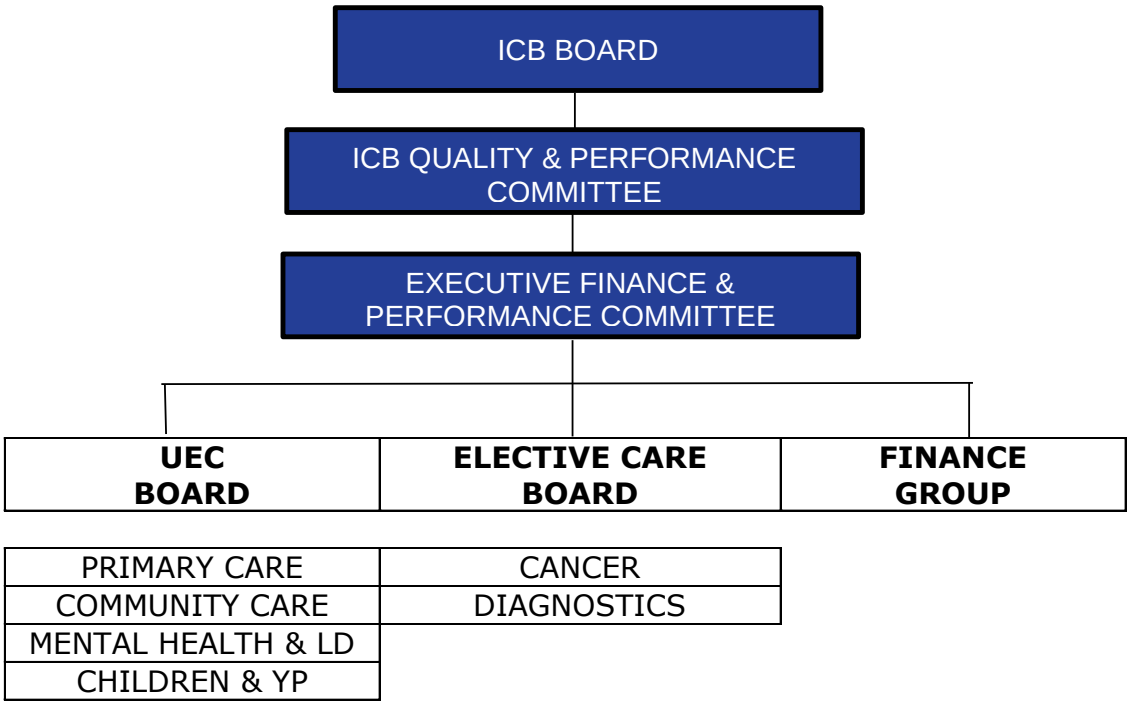
Expanding and better joining up health and care outside hospital • expanding and better joining up new types of care outside hospital • Expanding virtual wards	Director of Primary Care	COO / CMO
Making it easier to access the right care	Locality Directors	TBC

7.4 Delivery of local plans will be monitored by regional and national teams, providing oversight, support, and intervention as appropriate to ensure delivery of the plans.

7.5 Each Trust will develop its own ***integrated performance improvement plan*** that will identify improvement actions for both UEC and elective care to be delivered:

- locally within the Trust
- at 'place' in conjunction with local partners in health, social care, and the voluntary sector
- at 'system level' through joint working with other Trusts, the ICB and independent sector

Fig 4 - IMPROVEMENT GOVERNMENT ARRANGEMENTS



NHS Devon

NHS Devon Integrated Care board meeting

Integrated Quality, Performance and Finance Report (IQPR)

Date of committee	Date report produced
February 2023	26 January 2023

Author(s)		Report approved by	
Name and title:	Performance Team	**Name and title:**	Sam Wadham-Sharpe Director of Performance and Assurance
Phone:		**Date:**	1 December 2022
Email:			

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary
This report provides a consolidated update on key strategic issues and measures of outcomes, performance, quality, finance, and activity to provide the necessary assurance to the ICS, at both place and system level that issues are being identified and addressed. Operationally in December the ICS remained under extreme pressure with increasing Covid / Flu inpatient numbers combined with an upturn in community infections placing pressure on primary care. This alongside industrial action in nursing and ambulance services has resulted in further extended delays in urgent care, ambulance conveyancing and waiting times, with a resultant impact to patient care. A loss of 13,743 ambulance hours due to

handovers was seen in December compared to 9,778 in November. These pressures resulted in a system wide critical incident being declared on the 28 December 2022 and stood down on the 4 January 2023.

Patients with No criteria to reside (NCTR) increased in December due to infection protection control (IPC) impacts, staffing vacancies and industrial action after reductions in the earlier winter months as winter funding plans delivered extra capacity. Average length of stay increased further in December in most providers and remains significantly higher than previous years. Mitigations have been implemented to reduce risk and improve performance and these will be reviewed within the context of the revised operating framework.

There remain significant numbers of patients waiting beyond 104 weeks and at the end of November this figure sat at 408 which is an improvement of the October 590. The system has seen a worsening in performance in referral to treat (RTT) at 52.9% compared to a target of 92% and in diagnostic pathways at 64.4% versus a target of 99%. Providers are now sharing their information on harm, including lower-level incidents and complaints. This is being reported in January to the NHS Devon Quality & Performance Committee and an audit of serious incidents will be reported in February 2023. NHS Devon has also undertaken an audit against the Healthwatch Report Recommendations (2021) around long waiting patients to be finalised in January. Elective recovery plans are being reviewed with additional support being provided by NHSE.

In December approval was received from NHSE South West to move the financial position to £52m deficit as the risks previously declared have crystalised and this was signed off at the NHS Devon Board on 21 December 2022. Subsequent, national support funding of £2.5m has been notified to improve the position to £49.5m deficit which is the current forecast.

Statistical Process Control (SPC) charts have been introduced into the IQPR to demonstrate the system performance alongside the NHSE accepted standard reporting format. The use of this reporting has been included for primary care this month and dashboards developed for workforce and quality. The table in the page above explains how to use the icons in the SPC charts to understand performance against the metrics displayed.

Committees that have previously discussed/agreed the report, and outcomes of that discussion

Quality and Performance Committee
Finance Committee
NHS Devon Board
Outcomes would be escalated as part of chair reports

Key recommendations and actions requested

The board are asked to note the report

Impact on NHS Devon objectives

Objective	Impact
Improve population health	
Improve services and reduced unwarranted variation	

Make more efficient use of our resources

Develop our culture and how we operate

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services	Outlines current operational and quality performance and actions	
Health inequalities		
Workforce	Outlines current workforce performance and actions	
Resources and finance	Outlines current financial performance and actions	
Legal		
Engagement and consultation		

NHS Devon has made every effort to ensure this report does not discriminate (directly or indirectly) against employees, patients, contractors, or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

Integrated Quality, Performance and Finance Report (IQPR)

Owner: Performance Team

January 2023

FINAL Version

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Acronyms

Acronym	Full Meaning	Acronym	Full Meaning	Acronym	Full Meaning
AAU	Acute Assessment Unit	ICA	Integrated Care Area	PPG	Practice Plus Group
ADHD	Attention Deficit Hyperactivity Disorder	ICB	Integrated Care Board	RDUH/N/E	Royal Devon University Hospitals/North/East
AMU	Acute Medical Unit	ICS	Integrated Care System	RHA	Review Health Assessment
ARI	Acute Respiratory Infection	IHA	Initial Health Assessment	RSV	Respiratory Syncytial Virus
ARRS	Additional Roles Reimbursement Scheme	IPC	Infection Prevention Control	RTT	Referral To Treatment
ASD	Autism Spectrum Disorder	IR	International Recruitment	SDEC	Same Day Emergency Care
BAU	Business As Usual	IS	Independent Sector	SEND	Special Educational Needs and Disability
BPTW	Best Place To Work	IUCS	Integrated Urgent Care Service	SLT	Speech and Language Therapist/Therapy
CFHD	Children and Family Health Devon	KPI	Key Performance Indicator	SMI	Severe Mental Illness
CIC	Children In Care	LOD	Length Of Delay	SOP	Standard Operating Procedure
CLD	Criteria Led Discharge	LOS	Length Of Stay	SW	South West
CYP	Children and Young People	LSW	Livewell South West	SWASFT	South West Ambulance Service Foundation Trust
CW	Care Worker	MAU	Medical Assessment Unit	SWP	Strategic Workforce Planning
D&C	Demand & Capacity	MH	Mental Health	TDSAP	Torbay and Devon Safeguarding Adult Partnership
DCC	Devon County Council	MOU	Memorandum Of Understanding	TP	Trans-Perineal
DEXA	Dual Energy X-ray Absorptiometry	MRSA	Methicillin-Resistant Staphylococcus Aureus	VCSE	Voluntary Community Social Enterprise
DPT	Devon Partnership Trust	MRI	Magnetic Resonance Imaging	WIC	Walk In Centre
DTA	Decision To Admit	NCTR	No Criteria To Reside	WSOA	Written Statement of Action
ED	Emergency Department	NHSE	NHS England	WTE	Whole Time Equivalent
EMD	Emergency Medical Dispatcher	OOH	Out Of Hours	WW	Week Wait
FY	Financial Year	OPEL	Operational Pressures Escalation Levels		
G&A	General & Acute	PALS	Patient Advice and Liaison Service		
GI	Gastro-Intestinal	PCN	Primary Care Network		
HEE	Health Education England	PHSO	Parliamentary and Health Service Ombudsman		
IAPT	Improving Access to Psychological Therapies	PITCH	Peer Improvement Tips for Care and Health		

Key to Variance & Assurance Icons

	Variation/Performance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

	Assurance Icons		
Icon	*Technical Description*	*What does this mean?*	*What should we do?*
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Executive Summary

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Operationally in December the ICS remained under extreme pressure with increasing Covid / Flu inpatient numbers combined with an upturn in community infections placing pressure on primary care. This alongside industrial action in nursing and ambulance services has resulted in further extended delays in urgent care, ambulance conveyancing and waiting times, with a resultant impact to patient care. A loss of 13,743 ambulance hours due to handovers was seen in December compared to 9,778 in November. These pressures resulted in a system wide critical incident being declared on the 28th December 2022 and stood down on the 4th January 2023.

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There are significant numbers of patients waiting beyond 104 weeks and at the end of November this figure sat at 408 which is an improvement of the October 590. The system has seen a worsening in performance in RTT at 52.9% compared to a target of 92% and in diagnostic pathways at 64.4% versus a target of 99%. Providers are now sharing their information on harm, including lower-level incidents and complaints. This is being reported in January to the ICB Quality & Performance Committee and an audit of serious incidents will be reported in February 2023. The ICB has also undertaken an audit against the Healthwatch Report Recommendations (2021) around long waiting patients to be finalised in January. Elective recovery plans are being reviewed with additional support being provided by NHSE.

In December approval was received from NHSE South West to move the financial position to £52m deficit as the risks previously declared have crystalised and this was signed off at the ICB Board on 21st December 2022. Subsequent, national support funding of £2.5m has been notified to improve the position to £49.5m deficit which is the current forecast.

Statistical Process Control (SPC) charts have been introduced into the IQPR to demonstrate the system performance alongside the NHSE accepted standard reporting format. The use of this reporting has been included for primary care this month and dashboards developed for workforce and quality. The table in the page above explains how to use the icons in the SPC charts to understand performance against the metrics displayed.

Quality	Operational Performance	
• **Planned Care:** risk to patients, due to long waits. Harm profiles received from providers • **Urgent & Emergency Care:** delays to handover and risk to patients across pathway, including at home due to ambulance conveyancing times • **IPC**: Increasing numbers of COVID-19 positive cases, flu and Strep A impacting on communities, hospitals, and workforce. • **Primary Care:** IPC impact on primary care workforce and workload due to increased community infections and staff sickness	**Planned Care** 	RTT, Diagnostic and most Cancer metrics continue to fail the national targets. The system has seen a continued improvement in the total number of patients waiting over 104 weeks from referral to treatment falling from 590 to 408, since last month. However. the number of patients waiting over 52 weeks continues to increase.
	UEC 	All metrics remain under extreme pressure. Emergency Department 4-hour performance declining (38.6%). Loss of 13,743 ambulance hours due to handovers compared to 9,778 in November 2022. Average Cat.1 handovers at 13 mins. and Cat 2 at 151 mins.
	Discharge 	Significant improvement in the number of beds occupied by patients with “no criteria to reside”, during early January but bed availability remains under pressure from historically high non-elective length of stay across the system, this is most evident at UHP and RDUH(N).
	Primary Care 	Impacted by community infections. Access targets are delivering required performance with exception of 2-week access metric which is slightly below target. However, primary care remains under pressure and performance is fluctuating around required targets.
	Children 	Referrals for both SLT and ASD remain within expected levels and average waiting times are significantly higher than the 18-week targets. Both services are impacted by staff vacancies and recruitment challenges. Pathway redesign and additional funding are being implemented to improve service position.
	Mental Health 	No significant variation across most metrics, although improvements have been made in perinatal access and physical health checks for patients with SMI. CYP eating disorder services continue to be challenged by staff vacancies which impacts on timely access to services.

Finance	
As at end of December 2022 the Devon ICS is reporting a year to date £29.3m deficit against a planned deficit of £17.4m – an adverse variance of £11.9m (M8 £7.4m variance)	↓
The reported forecast is a deficit of £49.5m which is £31.3m adverse to the planned deficit of £18.2m. (M8 £0 variance)	↓
As at month 9 the Devon ICS had made efficiency savings of £73.1m (M8 £64.4m) This is £24.5m adverse to plan. (M8 £19.8m).	↓
Forecast savings are adverse to plan by £35.1m (M8 £29.8m).	↓
At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. At the end of month 9, this has improved by £46.4m and stands at £49.5m (M8 £51.8m) is against an expectation of break-even (£31.3m against plan) and £0 risk to the current forecast.	↑

Operational Performance

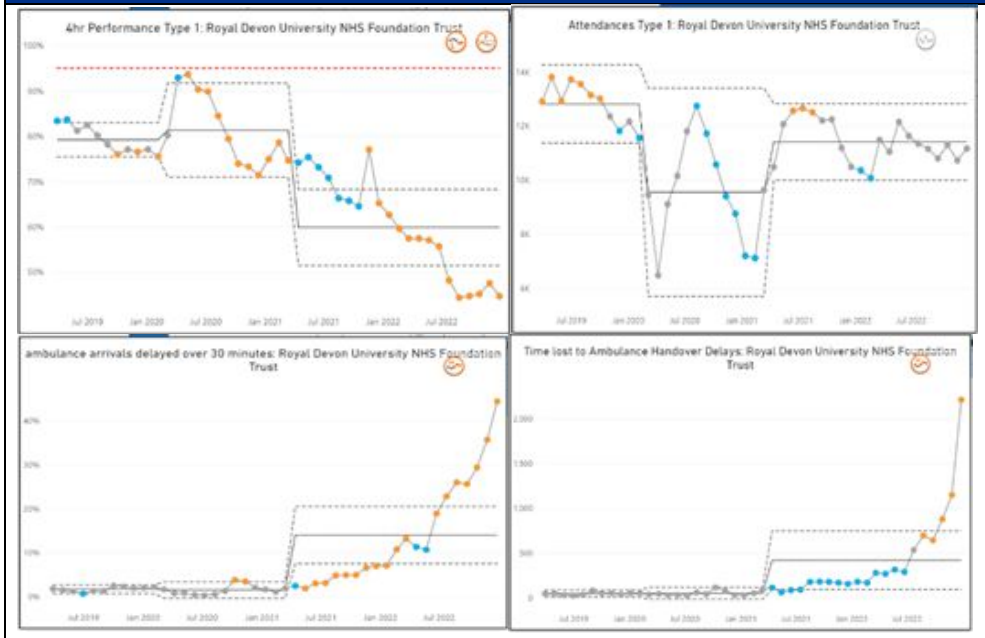
Urgent and Emergency Care – System Overview

			System				Royal Devon University NHS Foundation Trust			Torbay and South Devon NHS Foundation Trust			University Hospitals Plymouth NHS Trust		
	Metric	Target	Latest Date	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance	Value	Variation	Assurance
UEC	Attendances Type 1		2022-12	25668			11160			6063			8445		
	Type 1 Admissions (conversion rate)		2022-12	28.4%			30.8%			24.8%			27.7%		
	Emergency Admissions via A&E		2022-12	7280			3433			1505			2342		
	ambulance arrivals delayed over 30 minutes		2022-12	58.4%			44.4%			70.8%			75.5%		
	4hr Performance Type 1	95%	2022-12	38.6%			44.7%			27.4%					
	12 hr trolley waits	0	2022-12	2007			651			367			989		
	Time lost to Ambulance Handover Delays		2022-12	13,743			2,214			4,201			6,275		
	Mean ambulance response times cat 1	7	2022-12	13.0											
	Mean ambulance response times cat 2	18	2022-12	151											

Metrics relating to urgent care have seen no significant improvement in December 2022 with ambulance handover delays significantly above the 15-minute target with delays totalling 13,743 hours and type 1 four-hour performance dropping from 42.9% in November to 38.6% in December. Nursing and ambulance industrial action has contributed to pressures and despite attendances stabilising, admission numbers and ambulance delays have increased with the Devon system declaring a critical incident on 28th December 2022.

Urgent and Emergency Care – Royal Devon University Healthcare

Data



Analytical Summary

- All analytic charts show that RDUH continued to struggle in December to meet the challenges presented via the ED front door directly impacting on SWASFT and their service provision.
- There continues to be a statistically significant upward trend in the number of ambulance arrivals delayed for over 30 minutes and total time lost to handover delays
- There is a statistically significant downward trend 4-hour performance below the target.
- ED attendance numbers show no significant variation.
  - Type performance against the 4-hour wait target declined to from 49.2% to 44.7% in December.
  - 12-hour trolley wait for a bed following a decision to admit increased from 514 in November to 651 in December.

Operational Summary

Causes (RDUH East)

- Ambulance handover delays are challenged although compare well with other trusts in the Southwest region.
- Higher average inpatient length of stay (LOS) compared to 2020/2021.
- Ongoing industrial action in nursing and ambulance services.
- Bed capacity pressure and restricted flow to beds in the hospital.
- Increase in flu and COVID infected patients further complicating flow out of the department.
- Reduced capacity at Sidwell Street WIC closed on Mondays and Thursdays.

- Current vacancies and sickness in workforce.
- ED Reconfiguration works.

To note

- ED reconfiguration of Majors completed 19th December increasing resus by 3 bays. A further 2 paediatric resus bays are planned in the next phase of the build.
- New ED reception and waiting room due to complete end of January 2023 with access to ED will be improved for patients.
- SDEC activity increasing with record throughput in December.
- Virtual Ward activity growing as pathways are developed with approximately 50 patients already cared for at home.

Actions

- Ongoing work to improve pathways for specialty expected patients.
- Focus on improving the 15 min to triage performance in ED. The team have undertaken a time and motion study to review steps in the triage pathway, to highlight opportunities to streamline the process. This included work with IT to streamline recording processes, nurse training and internal monitoring to review improvement progress.
- Development of further pathways in the Virtual Ward.

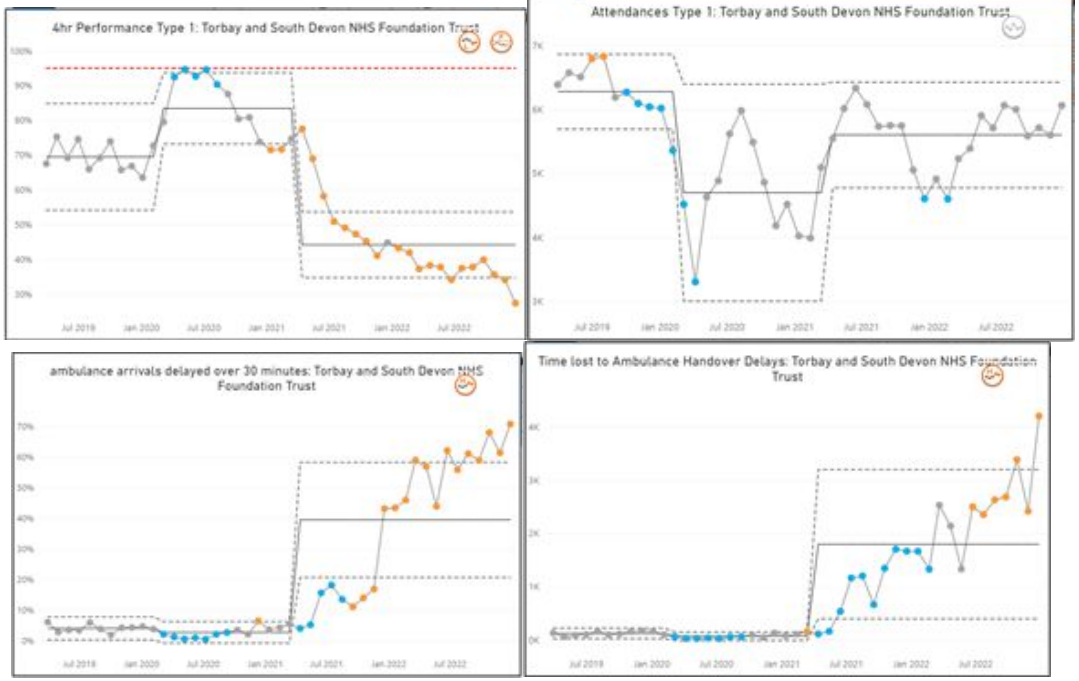
Causes (RDUH North)

- Bed capacity pressure and restricted flow to beds in the hospital.
- Higher average inpatient length of stay (LOS) compared to 2020/2021.
- Ongoing industrial action in nursing and ambulance services.
- Increase in flu and COVID infected patients – further complicating flow out of the department.
- Current vacancies and sickness in workforce.

Actions

- Virtual Ward currently under development.
- Plans for a new discharge lounge to include bedded patients at business case approval stage**.**
- Ongoing work to improve pathways and increase SDEC criteria.
- Focus on reducing 12-hour trolley waits in ED by improving patient flow due to additional SDEC capacity.
- Taskforce group set up to focus on patient flow as part of the silver and gold structure. Operational January 2023.

Urgent and Emergency Care – Torbay & South Devon

Data	Analytical Summary
	• All analytics show that TSDFT continued to struggle to meet the challenges presented via the ED front door directly impacting on SWASFT and their service provision. • There continues to be a statistically significant upward trend in the number of ambulance arrivals delayed for over 30 minutes and total time lost to handover delays • There is a statistically significant downward trend 4-hour performance below the target. • ED attendance numbers show no significant variation.

Operational Summary

Causes:

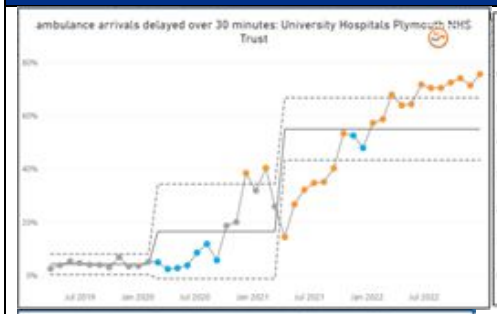
- Multifactorial issues created a scenario that hampered flow and the Trust was in OPEL 4/4+/Critical Incident for most of the December.
- IPC outbreaks affected up to 9 wards of the acute Trust and Community hospitals for most of the month. This was further mirrored in the care environments outside of the hospital settings. It also directly impacted the staff internal and external of the organisation due to their own sickness due to the pathogens affecting the in-patient spaces and impacted the ability to move pathways of care in a dynamic way.
- Due to IPC impact, increased use of on the day escalation bedding down in non-inpatient spaces, including the Discharge Lounge, Cath Lab and SDEC environments including the new AMU.
- Industrial action affected the Community and Domiciliary Care teams who were supporting Primary Care in hospital avoidance to support the ED.
- Group Strep A impacted on all settings of care with increased walk ins and on the day health enquiries, concerns and treatment. The ED numbers showed that a 12% increase in walk-ins was noted within the attendances and those that were within the ED had a higher acuity level, and greater crowding at midday (levels at midday was the same as midnight- showing poor flow and over-crowding).
- 10-day period across 2 bank holidays at Christmas meant that although business continuity plans were in place, the short-term sickness, vacancies and what is often weekend levels of staffing meant that core resilience and flow was impacted on.
- Crowded ED making it difficult to see, assess and treat in a timely manner, directly impacting on Decision to Admit times and bed holds, this included increased walk-ins due to much of the above.

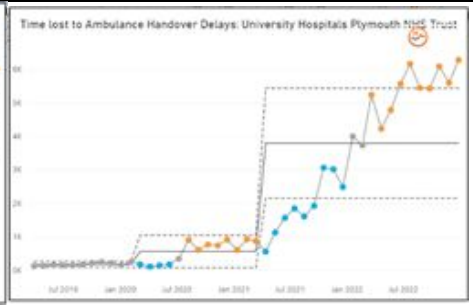
Actions:

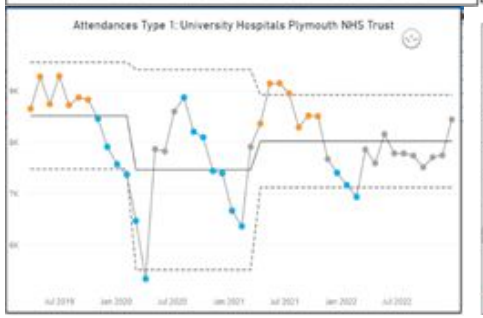
- Incident Control measures in place, and with constant senior to executive support to provide the check and challenge needed across all Integrated Service Units to help be as dynamic as possible. The consistent senior support across all meetings was a new support to enable real time challenge.
- Changes to the Trust internal reporting via the bed management team to ensure the data, actions and outcomes were being captured in a real time and quality way. Key focus via the bed management team on discharges prior to midday and weekends.
- Creation of IPC reporting channels and reporting to enable dynamic and transparent management of all in-patient environments and pathogens to enable full capacity usage of beds and cohorting as able- this has been adopted as BAU from December.
- Creation of a collaborative ambulance cohorting space and associated SOP within the acute Trust. The area, location and responsiveness has been challenging, but good partner working has enabled this to be reviewed and dynamically altered as able and necessary. This has yet to be stabilised but still be actively worked through.
- Senior clinical and operational review of all P1-3 patients, with full patient level detail to re-triage and add assurance that all appropriate usage of the multidisciplinary and collaborative teams being utilised effectively, and to down pathway as able. Active and real time feedback to the ward/unit to aid learning and insight in decisions being made at ward level as to timely referral to the Discharge Hub, utilisation of pathways and tighter Estimated Discharge Dates and discharge preparations.
- Assurance of dynamic use of all short-term Services/Community Nursing/external bed usage to aid the work above, building on the relational work with the private providers via the Trusted Assessors too take clients rapidly +/- infection and through the holiday period and utilising flexible care hours to support as needed.

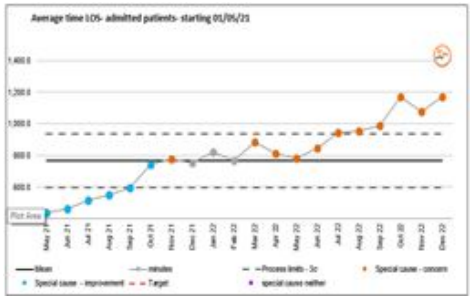
Urgent and Emergency Care – University Hospitals Plymouth

Data



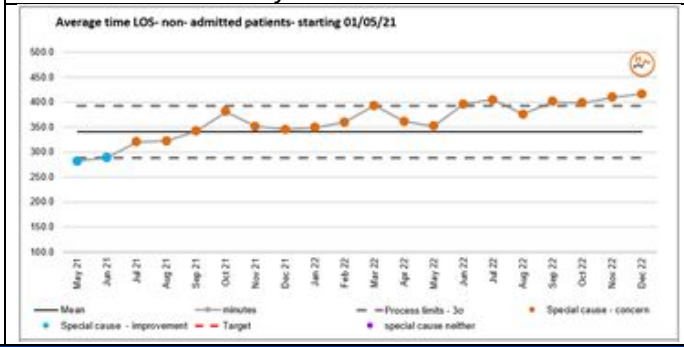






Analytical Summary

- The number of ED attendances is variable but is within the expected range.
- For admitted and non-admitted patients there has been a sustained upward shift in the length of stay in ED.
- There is a continuing statistically significant upward shift in the number of ambulance arrivals delayed over 30 minutes.
- There is a continued statistically significant upward shift in the total hours lost to ambulance handover delays.



Operational Summary

Causes:

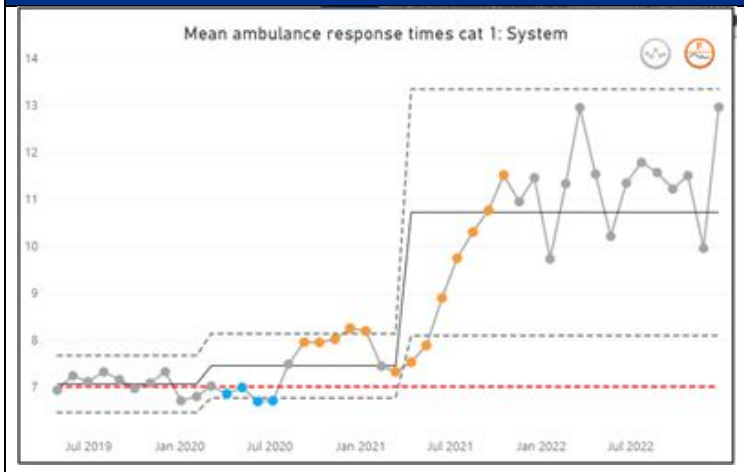
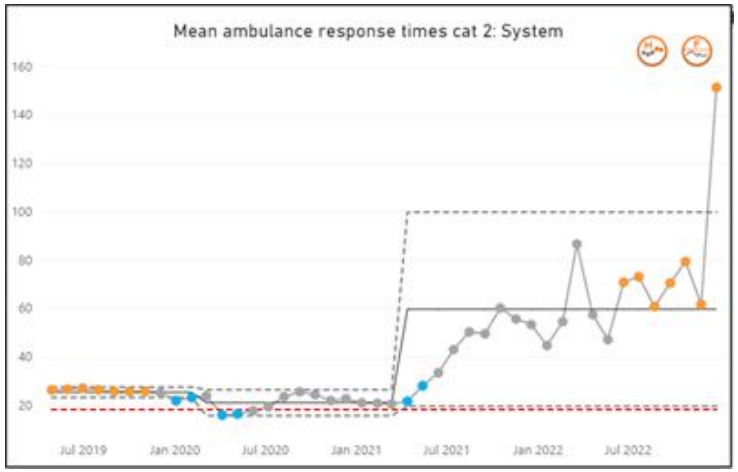
- Average LOS increased during December primarily due to Christmas and New Year bank holiday periods and industrial action from SWASFT and nurses, which has had a negative impact on flow into and from the acute trust. There has also been an increase in patients with NCTR. There has been a corresponding increase from 30 to 70 for the number of patients who are fit for discharge but delayed longer than 21 days.
- Late December saw a peak in flu and covid cases within the Trust resulting in closed wards and bays due to infection control.
- 50 to 60 walk in type 4 and 5 attendances (lower acuity presentations) per day that have not chosen or been able to access alternative pathways.
- Crowded ED, space constraints, resulting in delays in reviewing Decision to Admit (DTA) patients.
- SDEC constraints due to ability to provide senior cover, process & capacity limiting activity due to recruitment and sickness issues.
- Limited capacity within front door frailty assessment service limiting full impact of admission prevention.

- Deteriorating discharge position across all areas. Cornwall discharge position very challenging, average length of delay currently Cornwall 20.3 days. Pathway 2 is the most challenged pathway across the Cornwall and Devon footprint with a high increase in referrals to hospital discharge teams during the first 2 weeks of January.
- Trust in internal critical incident pre and post-Christmas which was compounded by the impact of industrial action.

Actions:

- Increased SDEC capacity and a restart of GP take through Medical Admissions Unit/Acute Ambulatory Unit. Medical Triage Unit (MTU) model in place in Acute Assessment Unit (AAU) and Medical Assessment Unit (MAU). Data collected and reviewed weekly to determine if this is assisting SDEC improvements. Frailty and SDEC aim for 50 episodes per day, currently averaging 35 per day. Recent IPC issues to overcome to improve flow for covid and flu patients.
- Audit of Criteria to Admit completed and to be presented to UHP Urgent and Emergency Care Board, outputs will be available for the next IQPR.
- Access to Frailty Unit via ED currently running at 3 per day, additional staffing in place end aiming for 6 patients per day.
- Increased resource for the Hospital to Home P1 service to reduce waits for access to service. Offering 26 slots per day, working towards 40 per day target after recruitment. Majority of patients have no care needs at the end of the service.
- Enhanced clinical support using Immedicare nurse-led remote technology to care homes with high admission rates. 33 homes live at 11/01/22, increasing to 15 by end of January and working towards total of 57. In December 119 consultations were received in hours and 82 out of hours. 92% of residents remained in place.
- Additional Dementia support scheme now live and fully utilised, 4 patients receiving 1:1 care 24 hours a day. Offering additional capacity to care homes to take more complex dementia patients and support discharge.
- Care hotel, 30 beds used for Devon and 10 beds for Cornwall, located in Plymouth to 31st March 2023 to provide social care for people who are medically fit and do not require hospital care, but do need additional living support after a stay in hospital or to prevent them from needing to be admitted.
- Independence at Home bridging service, 10 additional staff to support P1 patients at home following their discharge from hospital resulting in 21 additional slots per month
- Targeted work with Cornwall Integrated Care Area (ICA) to challenge LOD position including support with joint commissioning arrangements and shared improvement approaches in place with weekly review meetings.

Ambulance response times (Cat 1 and Cat 2)

Data	Analytical Summary
 	Ambulance response times are influenced by overall levels of demand, call answering times and capacity to respond which is heavily influenced by hours lost to handover. **Demand**: The number of call outs have been increasing since mid-October, sharply from the end of November to end December (circa 18,400 incidents in November, 21,500 in December), however in January activity is now back below 2019, 2020 and 2021 levels. The percentage of patients conveyed to ED was lower than in previous months, 28% in December, compared with 36% in November. **Call answering**: Answering times in December dropped to 35% of calls answered in 5 seconds (target 95%), 55% in November. Mean call answering time, was 126 seconds, a significant increase from November at 26 seconds. **Response capacity**: Over 50,000 conveying resource hours were available across the south-west through December, the highest number since the reporting started in August 2019. This increase in response capacity has been put in place to partly mitigate resource lost to handover. Across the Trust, during December nearly 61,400 hours were lost to handover against an improvement trajectory of 13,500 hours. Nearly 18,000 hours were lost in Devon, against an improvement trajectory of 5,360. **Response times**: There has been a statistically significant upward shift in the mean response time for both category 1 and category 2 since mid-2021. The targets of 7 minutes for category 1 and 18 minutes for category 2 will not be met without further intervention.

Operational Summary

Causes:

1. December saw a day of industrial action for ambulance services; however, this did not seem to impact on performance primarily due to a change in public behaviour requesting ambulances. There was an impact on the operational delivery of the service and a concern that patients may have delayed accessing care.
2. Ambulance response times have a positive correlation with hospital handover delays. SWASFT category 1 mean response times were the worst in England in December at 12.40 minutes mean, against a target of 7 minutes. The range of response times nationally was 9-12.40 minutes. Category 2 response times are again the worst in England; in December, the SWASFT response mean response time was 2 hours 31 minutes against a target of 18 minutes. The range of response times nationally is 42 minutes to 2 hours and 31 minutes. SWASFT continue to have the highest average handover times in England: 1 hour 9 minutes in November; the national range of average handover times across ambulance Trusts ranges from 16 minutes to 1 hour and 9 minutes.
3. Call answering times are influenced by duplicate/subsequent calls, which currently accounting for 28-34% of all call activity. These call rates increase when handover delays are higher, as callers ring back to escalate cases, get an update on response time etc.

Actions:

4. All systems have submitted trajectories to reduce hours lost; however, the trajectory is not being met. Handover improvement plans are in place for Derriford and Torbay, monitored fortnightly through the Devon Ambulance Cell.
5. SWASFT advertising a “pathway to paramedic” where recruits start as an EMD, there continues to be significant interest in the role. In addition, all EMD adverts have been reviewed and refreshed, online “open evenings” held, and recruiters used as a new recruitment platform. Videos for key roles are in place. Retention payments are also offered to EMDs. Up to end December, there were 208 WTE emergency call takers in place; this rate is stable.
6. To mitigate the effect of handover delays on response times, SWASFT are providing additional conveying resource each week (double crewed ambulance and patient support vehicles) than their “People Plan 2” forecast suggests would normally be required. This includes the provision of third-party ambulance response. During winter, a “risk share” has been agreed across all the south-west systems. If hours lost to handover across the south-west increase above 3900 hours per week, additional payments are made to SWASFT against the system trajectory and SW position. The funding will purchase additional response resource, including third-party provider. Since October, the full risk share has been payable (£800k per month); the Devon payments amounted to £219k in October and £250k in November; December payment to follow.
7. A SW transformation sub-committee is overseeing the delivery of the 2022-23 transformation plan. There are three priorities:
    - Availability of alternative response models and electronic referral (for example, Urgent Community Response). From 11th January, an electronic link from SWASFT to the IUCS provider was put in place to allow low acuity calls to be transferred from the 999 call stack for clinical review and onward referral. Alternative response may include SDEC, mental health crisis response, falls response, etc.
    - Access to clinical information (summary care record) - in lieu of electronic shared records, all systems have been asked as of 17th January 2023 to make paper copies of personalised care plans available in patient’s homes for ambulance crews – these include end of life care plans and treatment escalation plans.

Simplified pathways to support 999 with appropriate redirection of the patient - the Simplified Pathway Group agreed three priority acute pathways in November: paediatric advice for under 1s (and ideally under 5s), low risk chest pain and abdominal pain. Localities and Trusts have been asked to prioritise these pathways in their local ambulance improvement plans, with oversight of progress at the ambulance cell.

Winter Demand and Capacity Programme (D&C)

As part of winter planning Devon ICS was awarded £24m of non-recurring funding to support extra capacity equivalent to 377 beds by March 2023. This funding has been split across the following schemes to support flow and discharges and as at the end of December 274 beds had been opened which is 38 below target and primarily relates to the mobilisation of virtual wards in the south and use of SDEC beds in the West.

Scheme	Total Planned Beds	Planned beds at 31/12/22	Achieved Beds at 31/12/22	Total Scheme Cost £'000	Spend to date £'000	RAG Rating
Western LCP	92	79	68	8,636	3,940	A
Southern LCP	89	65	64	4,130	1,797	G
Northern & Eastern LCP	93	76	77	7,153	3,021	G
Mental Health	7	7	7	1,000	500	G
Virtual Wards	96	85	58	2,000	0	A
IUC Service	0	0	0	1,000	1,000	G
Total	377	312	274	23,919	10,258	

Virtual Wards:
RDUH have 50 beds live although occupancy remains variable daily. As of 10th January, 23 beds were in use.

UHP 25 beds went live in December, however there is phasing of utilisation according to Consultant capacity.

There have been delays in the southern LCP regarding data flowing from internal provider IT systems and recruitment, they are now predicted to come online in April 2023 with an intended 25 beds.

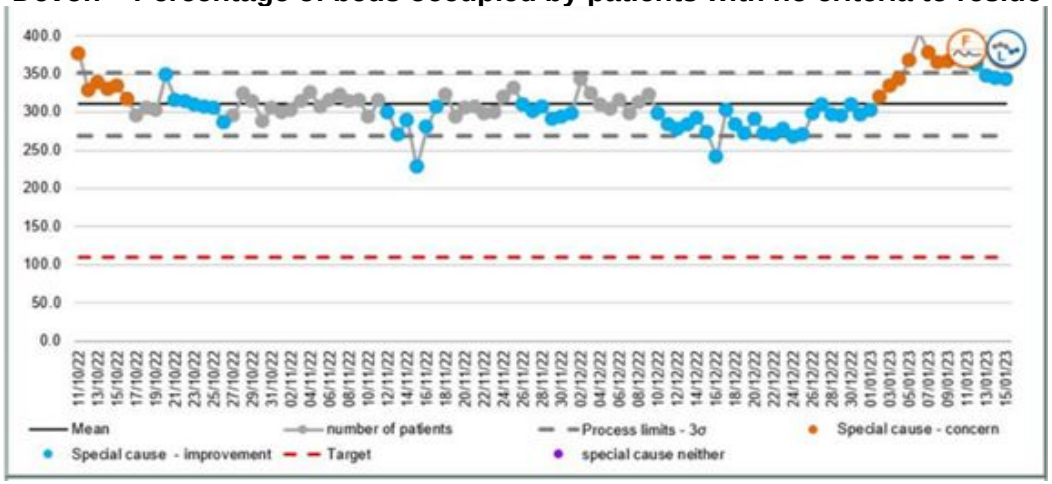
Western LCP:
Staffing restrictions impacting on opening of all beds especially in the SDEC setting.

Further detail on other schemes is provided in the narrative below on discharges.

Hospital Discharge

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
No Criteria to Reside (NCTR)	5%	18/01/23	16%		

Devon – Percentage of beds occupied by patients with no criteria to reside



Analytical Commentary: Devon has a target of no more than 5% (110) of General and Acute beds occupied by patients with no criteria to reside (NCTR). There has been statistically significant improvement in early January, and as of 15th January 2023, across all 4 acute sites 16% (343) of beds were occupied with patients who had NCTR.
The increase in NCTR post-Christmas has several contributing factors including industrial action throughout December and early January, increase in IPC infections resulting in absence of staff and closure of wards/beds, bedding discharge lounges, outbreaks within community settings and COVID infections resulting in a fall in community capacity and staffing absences. Due to limited staffing and capacity this has meant schemes are not fully embedded including Criteria Led Discharge (CLD). Further funding to support discharges until 31st March 2023 and plans are being finalised.

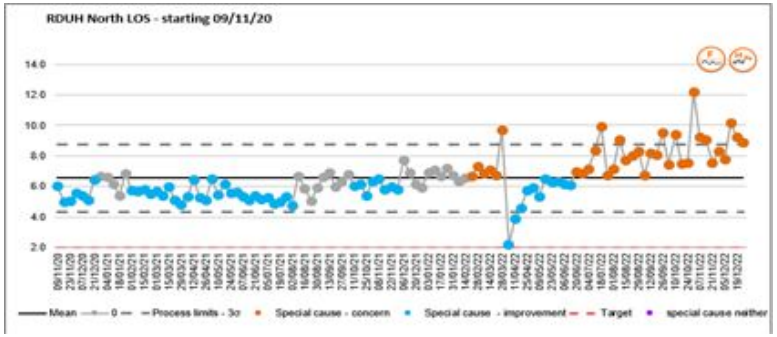
Operational Summary: Actions to address reducing the NCTR position are managed through System Flow group and providers and localities are required to provide assurance on the following:

- Target of 80% of P0 planned discharges by 5pm all trusts are now recovering from Critical Incidents and reopened their discharge lounges and promoting with wards with low referral rates
- Home for Lunch initiative through use of board rounds and identifying patients the day before
- Target of 60% of weekday discharges to be achieved at weekends by embedding CLD and recruitment of 7 day working Discharge Co-ordinators and ward clerks.

- Reducing Length of Delay on complex Pathways 1 to 3 through the use of additional capacity schemes including Care Hotels and reablement care home beds and 1:1 support packages for those with complex Dementia and new funding for step down bedded reablement placements.

RDUH North NCTR

Average Non-elective Length of Stay – RDUH North



Analytical Commentary: As of 15th January 2023, RDUH Northern reported 18% (50) of G&A were occupied by patients with NCTR. The Trust had a small increase in NCTR post-Christmas which was mirrored across the whole system. RDUH saw a trend of significant improvement since early December. P0 and weekend discharges have been the biggest challenge recently due to availability of staff.

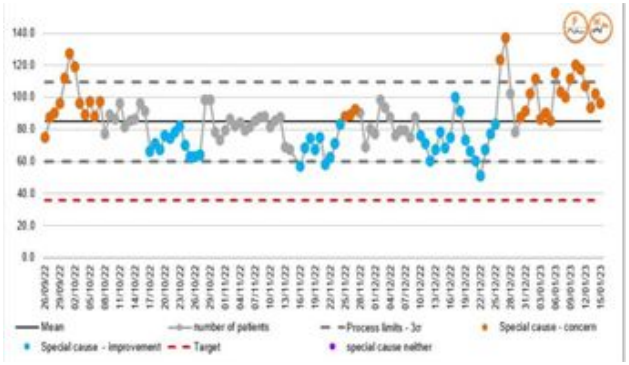
Operational Summary:
Actions to address are in place with Winter Demand and Capacity plans continuing to progress. The LOD performance breakdown by pathway is described below:

- P0 – Discharge has varied, and discharge numbers had reduced but balanced due to reduction in admissions. Discharge lounge remains open and is being utilised and CLD is being embedded but recent challenges and availability of staff have impacted on progress.
- P1 - Following the increased workforce capacity to support reduction in LOD for those on P1 since the mid-October average LOD on P1 is 14 days. There has been a positive downward trend to mid-January reporting at 5 days for average LOD.
- P2 - All 14 beds are now live. Since mid-October average LOD on P2, is approx. 13 days. Following an increase in LOD on P2 during Christmas period there has been a positive downward trend of improvement in early January, reporting at approx. 8 days for average LOD.
- P3 -. Since mid-October average LOD on P3 has dropped to approx. 29 days. There has been a positive downward trend of improvement since mid-November, reporting at average of approx.15 days in early January.

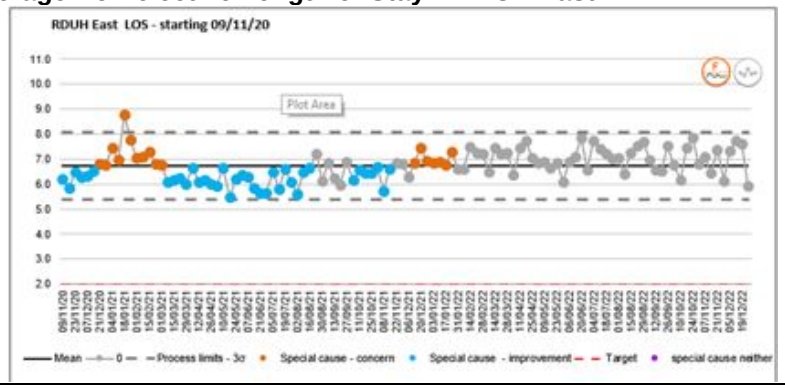
The average non-elective length of stay at RDUH North has remained above the two year mean of 6.5 days since July 2022 and has yet to show sustained reduction or return to pre-COVID levels.

Due to relatively small volumes at this site, small numbers of patients with very long LOS can cause spikes in the graphs.

RDUH East NCTR



Average Non-elective Length of Stay – RDUH East



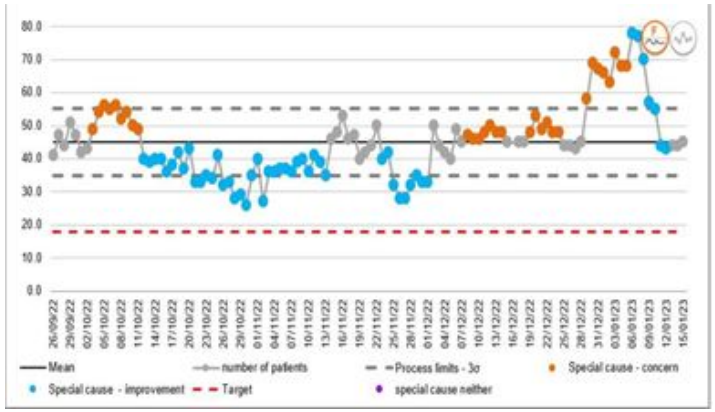
Analytical Commentary: As of 15th January 2023, RDUH Eastern reported 13% (96) of G&A beds were occupied by patients with NCTR. The Trust had an increase trend of NCTR following Christmas and the actions are continuing to improve this including early preparation for weekend discharges and then reviews if weekend discharges failed. CLD continues to be embedded whilst promoting the of use of discharge lounge.

Operational Summary:
Actions to address are in place with Winter Demand and Capacity plans continuing to progress. Below describes the Length of Delay performance breakdown by Pathway:

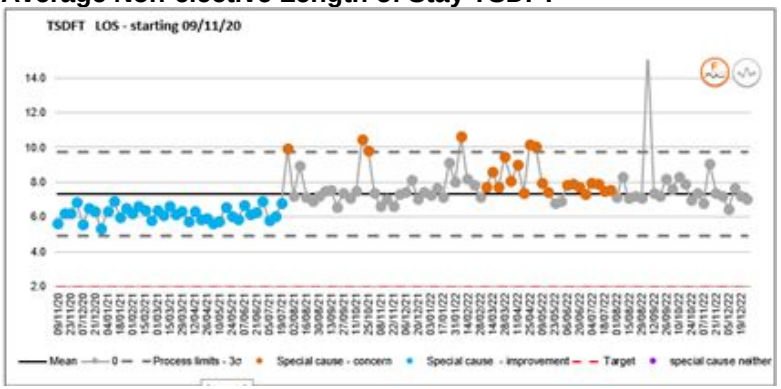
- P0 – Discharge lounge is open and CLD is being embedded. Deep dives into discharge delays due February 2023.
- P1 - There has been an increase Live in Carer resource and UCR Support to SWASFT capacity to support reduction in LOD. Since mid-October average LOD is just under 4 days.
- P2/P3 - 5 out 15 beds are now live with the remainder delayed from December into January due to provider readiness. Schemes include additional 1:1 support to support complex placements and additional reablement beds. Since mid-October average LOD for P2 is 5 days and P3 8 days. There is a consistent downward trend of improvement across both P2 and P3. Reporting at 3 days for P2 and 7 days for P3 in early January.

The average non-elective length of stay at RDUH East is marginally above pre-COVID levels but does not give cause for concern.

TSDFT NCTR



Average Non-elective Length of Stay TSDFT



Analytical Commentary:

As of 15th January, TSDFT reported 12% (45) of G&A beds were occupied by patients with NCTR. The Trust had an increase trend following Christmas due to factors mentioned above which affected the whole system. Over recent weeks the Trust saw improvement within NCTR position following 28th December critical incident. Trusted Assessor model implemented and seen an improvement in discharges on P2 and P3.

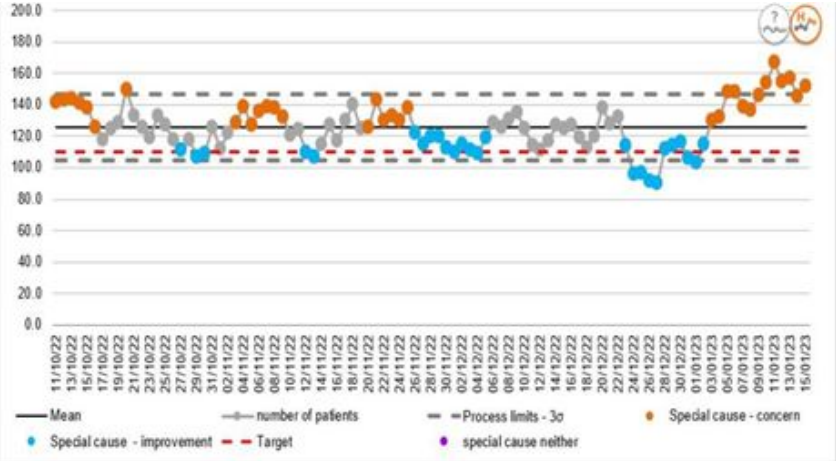
Operational Summary:

Actions to address are in place with Winter Demand and Capacity plans continuing to progress. Below describes the Length of Delay performance breakdown by Pathway:

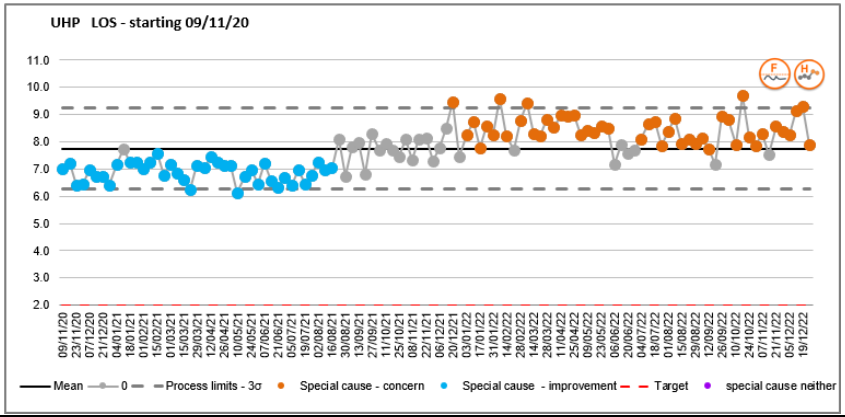
- P0 – High levels of IPC issues impacted on the performance of P0 discharges, during escalation the Discharge Lounge was converted to beds but has now reverted to a discharge lounge during the day and used for escalation beds if needed for evenings and weekends.
- P1 - Although no additional winter plans have been input to P1, since the 03/10 average LOD on P1, is 4 days.
- P2 - 27 out of 32 new capacity beds are now live with the remainder expected by January/February 2023. The average LOD fluctuated during the Christmas period however early January there has been an improving downward trend, reporting at approx. 3 days for average LOD.
- P3 - 20 new beds to support P3 discharges are expected in the coming winter months. Since the early October average LOD for P3 has remained at 10 days due to covid/flu/norovirus outbreaks within care homes.

The average non-elective length of stay at TSDFT has settled around the long-term mean (over the last two years), above pre-COVID levels, this is in line with other providers in the system.

UHP NCTR



Average Non-elective Length of Stay – UHP



Analytical Commentary:

As of 15th January 2023, UHP reported 18% (152) of G&A beds were occupied by patients with NCTR. The Trust had an increased trend of NCTR following Christmas which has not significantly reduced. Discharge teams saw a record number of referrals during last week which impacted on the increase seen in NCTR. Increased use of VCSE services supporting discharged is working well.

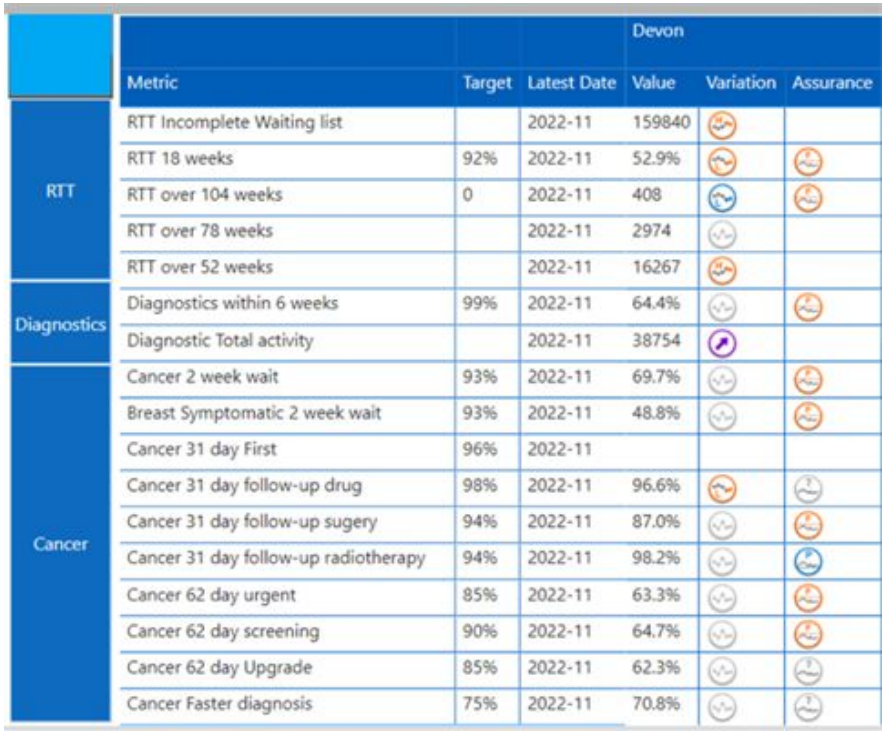
Operational Summary:

Actions to address are in place with Demand and Capacity plans continuing to progress. Below describes the LOD performance breakdown by Pathway:

- P0 – Night teams are reviewing P0 ready for discharge to get them discharged to the discharge lounge early in the morning.
- P1 - Full utilisation of the Care Hotel and increase VCSE capacity to support reduction in LOD for those on P1. The Care Hotel has 30 beds available to Plymouth LA and subcontracted 10 beds to Cornwall to support discharges from UHP. Since mid-October average LOD on P1, is 3.5 days. Following Christmas this did increase although has since reduced again.
- P2/P3 - All 6 beds providing 1:1 support for those awaiting a dementia care home placement is now live. Since the mid-October average LOD for P2 is 12 days and P3 16 days.

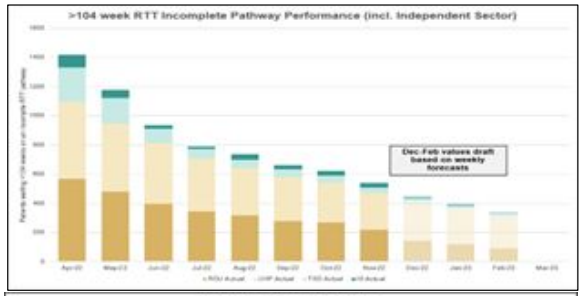
The average non-elective length of stay at UHP remains above the long term mean over the last two years, above pre-COVID levels. It has been routinely above the mean since December 2021. Further study is in train to understand the drivers behind this.

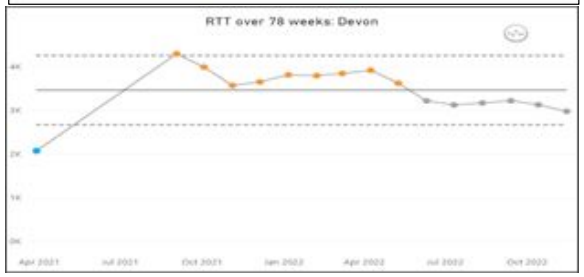
Planned Care: System Overview

Data	Summary
	System performance for November has remained within normal common cause variation indicating no significant change. However, the majority of metrics are failing to achieve national targets and will continue to do so without intervention. The system has seen a continued improvement in the total number of patients waiting over 104 weeks from referral to treatment, however a worsening in performance has been seen in RTT. Diagnostic activity has increased consistently over recent months with more capacity. The ICB Harm Group (including harm due to long waits), is planned to relaunch in February. A Planned Care update was reported through the ICB Quality & Performance Committee in January 2023, this provided provider level harm information as well as the positive results of an audit against the Healthwatch Report Recommendations (2021) around long waiting patients. More work is in train by providers to share information on the harm profile, including a summary of the PALS, concerns and complaints received as a result of long waits for planned care from RDUH. This information will be key to understanding the impact and informing the work the System are undertaking to ensure safety and improved patient experience whilst waiting.

Planned Care: System 104 Week Wait

Data





Analytical Summary

The 104 week waits measure is currently failing the target, there is special cause variation of an improving nature, however this has yet to achieve the target.

Operational Summary

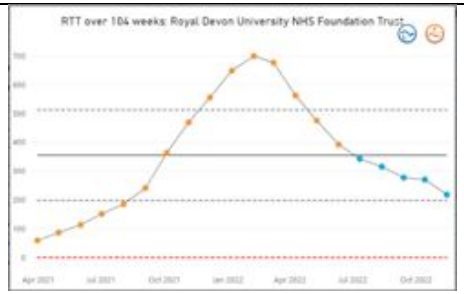
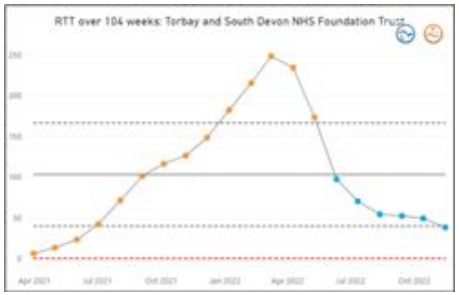
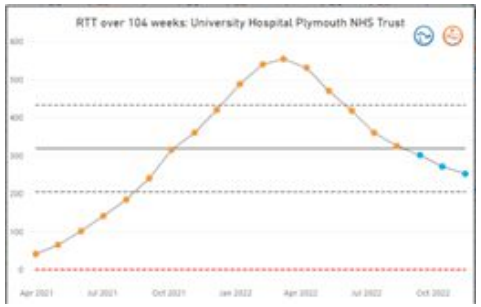
Despite industrial action and acute winter pressures over Christmas, all NHS acute providers managed to ensure most long waiting patients did not have their treatment affected.

A regular Devon ICS Paediatric Elective Recovery group has been established. A key priority for this workstream will be identification of priority procedures where the current general approach to elective recovery and prioritisation is inappropriate due to the risk of harm and the negative impact on a child's physical, social, and educational development.

With the local independent sector assisting NHS providers with treating long waiters, there was an increase in long waiting patients now sitting within the Devon Independent Sector (IS). To ensure appropriate prioritisation and focus on national targets, the planned care team is meeting weekly with the largest three IS providers to review treatment plans at patient level.

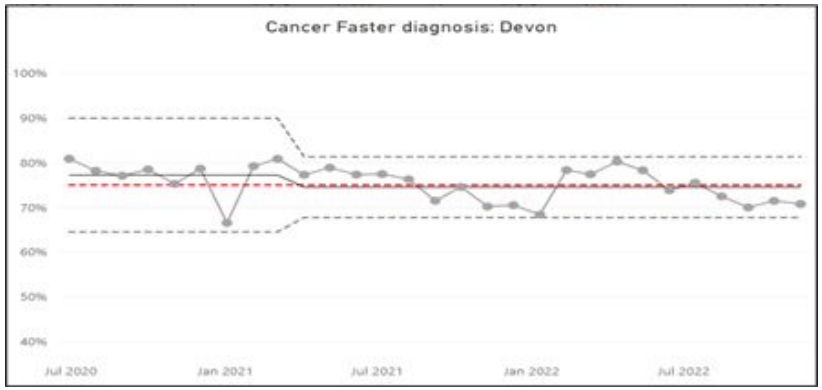
The rate of elective activity continues to be challenged by winter pressures, industrial action and competing emergency activity demands.

Planned Care: Trusts 104 Week Wait

	**RDUH Operational Summary** • The financial year end forecast of 37 patients waiting over 104 weeks has been sustained despite the UEC/workforce pressures and recent industrial action. • Between 19th December and the 8th January, 408 elective admissions were postponed due to industrial action of which 9 were >104ww and 3326 outpatient appointments of which none were >104ww. • With the national target of zero patients waiting over 78 weeks by April 2023 there has been increased focus on this cohort. The RDUH is currently on track to meet financial year end '10 week plan' revised trajectory of 1152, this is an improvement on the June 2022 operating plan submission trajectory which forecast 1477.
	**TSDFT Operational Summary** • Low volumes (less than 10 per speciality) of patients waiting over 104 weeks persist across the following specialties: Colorectal Surgery, Gastroenterology, Paediatrics, Neurology, Upper GI Surgery and Neurology. The organisation is continuing to forecast full clearance by financial year end. • Assessment of the impact of winter and industrial action pressures over the Christmas period on long waiters indicated that the organisation cancelled minimal activity for patients waiting >104ww (19 Outpatients and 2 Inpatients). TSDFT also had 29 same day admitted cancellations between 19th December and the 8th January but have confirmed that there should be no impact on >104ww or >78ww year-end positions. • TSDFT are forecasting no change to their 10 week plan revised trajectory of 196 >78ww by April 2023. This is an improvement on the June 2022 operating plan submission trajectory which forecast 305.
	**UHP Operational Summary** • UHP was the sole Devon organisation that submitted a 2022/23 operating plan trajectory showing patients waiting >104 weeks persisting into 2023/24. UHP are ahead of this financial year end forecast of 336, with a current assessment of 259 patients remaining, concentrated in the most challenged specialties of Neurosurgery and Orthopaedics. • Activity lost between 19th December and the 8th January due to the impact of winter pressures and industrial action was 48 elective admissions of which 4 were >104ww and 132 Outpatient appointments of which none were >104ww. There is a possibility this may impact the final 78ww position. • Cancellations have been flagged by UHP as possibly impacting progress on clearing >78ww patients. The latest forecast of 748 patients >78ww at financial year end is however better than both the June operating plan submission and '10 week plan' trajectory which predicted 1628 and 899 respectively.

Cancer 28-day faster diagnosis: System

Data



Analytical Summary

The Cancer 28-day Faster Diagnosis Standard (FDS) for the system, continues to exhibit common cause variation as it fluctuates around the target. October's performance is 70.8% against a 75% standard.

The system will not meet any of the 28-day trajectories this year and the individual Trusts have not consistently met the targets submitted for the operational plan this year.

The snapshot below of the last three months published data shows RDUH remain significantly off the 91% target at 67%.

Challenges in the diagnostic pathway for Lower GI, Urology, Gynaecology and Breast continue to be the greatest risks to achievement.

Operational Summary

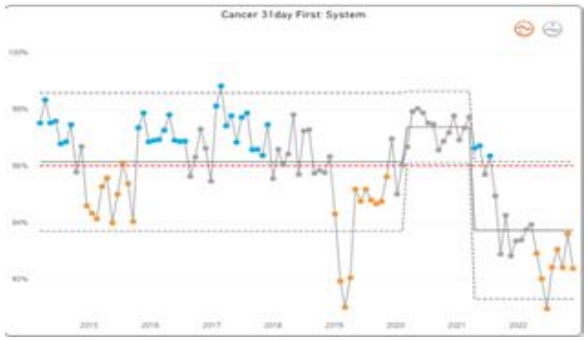
28-day performance 75%	Target	Sep-22	Target	Oct-22	Target	Nov-22
Torbay and South Devon NHS Trust	65%	68%	70%	74%	70%	68%
Royal Devon University Hospital - combined	90%	61%	90%	64%	91%	67%
University Hospitals Plymouth	77%	78%	80%	77%	78%	76%
ICS	75%	70%	75%	71%	75%	71%

UHP have been in Tier One (performance oversight meetings with NHS England), but this discontinued for cancer due to performance recovery in November. However, TSDFT and RDUH remain in Tier One and are accounting for delivery weekly to NHS England.

Actions:

- All Trusts continue to be monitored against delivery of imaging within the standard.
- All Trusts have a cancer recovery action plan in place. Trusts, ICS, and Cancer Alliance meet weekly to monitor and mitigate issues as they arise.
- 2ww recovery includes partial redirection to a provider in Plymouth for LGI and implementation of the FIT (Faecal Immunochemical Test) pathway.
- Additional capacity for prostate biopsies, endoscopy and gynae pathways is being commissioned through funding from ICB and Cancer Alliance.
- TSDFT are supported by the NHSE Intensive Support Team focussing upon the recovery of the cancer targets.

Cancer 31-day first treatment and 62-day urgent treatment: System

Data	Analytical Summary
	The Cancer 31-day metric is currently failing, there is no significant change or indication of improvement in this system wide. For November, performance was 92.4% against a 96% standard. The snapshot below of the last 3 months shows that all except RDUH have remained above the targeted activity they submitted for the operational plan this year. RDUH activity has increased steadily month on month, rising from 49% to 69% of the monthly target over the 3 month period shown in the table.
	The Cancer 62-day metric is consistently failing the target, it displays common cause variation. As the target is above the higher control limit, the system will currently not achieve this objective. For November, the Devon system performance was 63.3% against an 85% standard. Individual trust performance is shown below

31-day - first treatment activity	Target	Sep-22	Target	Oct-22	Target	Nov-22
Torbay and South Devon NHS Trust	171	178	170	198	219	210
Royal Devon University Hospital - combined	379	186	363	208	389	267
University Hospitals Plymouth	374	413	353	375	391	428

62-day performance -85%	Sep-22	Oct-22	Nov-22
Torbay and South Devon NHS Trust	58%	53%	57%
Royal Devon University Hospital - combined	59%	55%	57%
University Hospitals Plymouth	63%	57%	72%
ICS	60%	59.2%	63.3%

Operational Summary

The recovery work described for diagnostic elements of cancer pathways will temporarily worsen the 62-day position as more patients receive diagnoses and patients move along the pathway to treatment. This will appear as a bulge in demand. Planning is underway for 2023/24 to establish the diagnostic capacity that has been demonstrated as a shortfall this year. This process forms part of the 2023/24 operational planning work.

UHP have been in tier one oversight, but this ceased in November, however TSDFT and RDUH remain in tier one and are accounting for delivery weekly to NHSE.

The two most challenged tumour sites in the system for this standard are Urology and Lower GI. Staff vacancy rates and service capacity, particularly within diagnostic elements of pathways are the primary causes of pathways not meeting the standard.

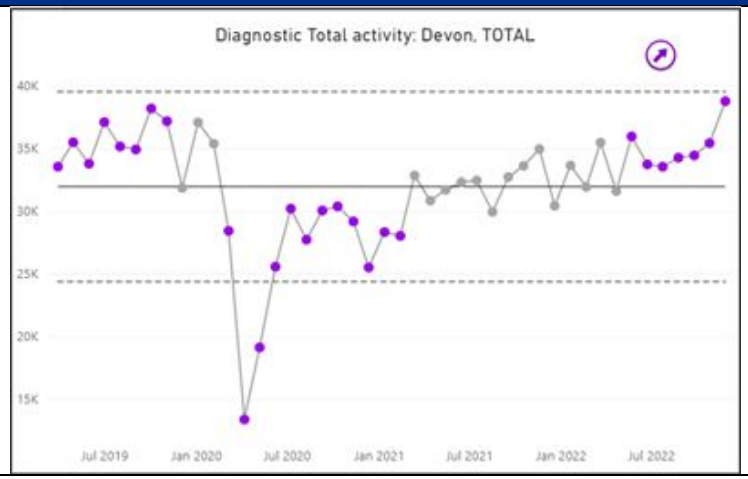
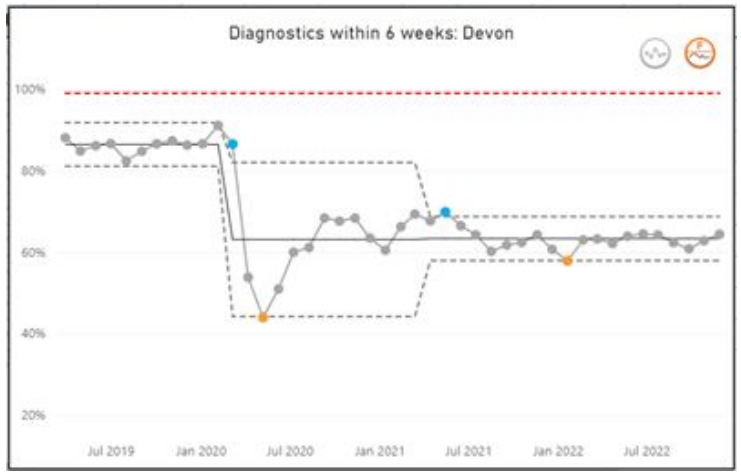
Actions:
Actions to improve diagnostics and deliver faster diagnosis standard also support 31-day and 62-day targets. Additional prostate biopsy commissioned from Nuffield to end of year for system began 3/10/22. This will deliver one 3 patient session each week.

Successful funding request via Cancer Alliance £1.8m will support capacity to deliver endoscopy, dermatology excision and biopsy activity trans perineal biopsies, cystoscopies, colposcopy and hysteroscopies across all providers, awaiting commencement dates from the Cancer Alliance which will inform trajectories and activity plans.

TSDFT
Dermatology weekend sessions commencing January 2023 until March will reduce the waiting list from 350 to below 200 and half the 6ww backlog from its current peak over 300 patients in the same timeframe.

A mobile unit for trans-perineal (TP) biopsies starts 21st January 2023 and projected to clear the TP biopsy waiting list, currently over 100 patients.

Diagnostics

Data	Analytical Summary
	**Activity** The total diagnostic activity has begun to show significant improvement. Improvement in activity has benefitted from additional capacity particularly MRI and Non-Obstetric Ultrasound as reported in December's activity return.
	**Performance** The system wide performance against the 6-week diagnostic standard continues to show common cause variation and is consistently failing the target despite an increase in activity. October's performance is 64.4% against a 75% operating plan target for patients to be seen within 6 weeks.

Operational Summary

The most challenged modalities are DEXA scanning, audiology, and endoscopy. Recovery planning for endoscopy is contained within the cancer update. Audiology compliance is not achievable in year due to issues with contract delivery for RDUH East.

Actions

RDUH:

Additional ultrasound capacity at RDUH North has been commissioned through an independent sector provider to commence January 2023 at Ilfracombe Hospital.

Non-Obstetric Ultrasound capacity has been commissioned in the North and will provide 1200 scans. The capacity commenced January 2023 and in the first week of operation, 458 Scans were completed compared to 231 the week before. This is more than double the number (221) of incoming referrals in the week and had an immediate positive impact on the waiting list which fell from 2134 to 2061 in the week.

Additional capacity is in place for gynaecology, including alternative weekends of hysteroscopy and colposcopy which will commence from 28th January to 31st March. This is projected to reduce the colposcopy active waiting list from 200 in January 2023 to below 50 before the end of the financial year and eliminate the backlog. Without the capacity this was projected expected to persist until September 2023.

Plans are in place for recovery of the non-imaging /endoscopy and reported through ICS Planned Care Board. There are modalities such as audiology (CHIME) and DEXA (RDUHN) that cannot be recovered in year to the target of 75% and additionally to waits beyond 26 weeks. The data from RDUH is inflated with electronic patient records that are being worked through but will not be resolved until April 2023. The position is understood and being discussed with NHSE to get to an agreed year end position.

TSDFT

Two new short-term schemes are planned to support capacity increases funded by the Cancer Alliance:

a) Elective Services support of the 3rd Endoscopy room during the existing planned weekends; and
b) The use of insourcing staff in 3 rooms on 2 days in January & February 2023 and on 4 days in March 2023.

The Trust has also changed one inpatient Gastroenterologist list every three weeks to release extra colonoscopy lists, on an on-going basis. These short-term measures will result in 398 fewer lower GI patients waiting by June 2023, before the 3rd Endoscopy room closes for re-development & expansion.

UHP

NHSE funded MRI scanner based at Plymouth Radiology Academy to continue scanning until end of 2023. To end of January 2023, 809 scans completed. Which has led to the UHP waiting list position improving.
Additional ultrasound capacity at UHP now delivering activity and will continue until March 2023. Additional ultrasound capacity at RDUH North has been commissioned through an independent sector provider to commence January 2023 at Ilfracombe Hospital.
Ongoing work to improve performance and develop Trusts' plans for the non-imaging /endoscopy modalities.

Primary Care Performance

Metrics

	Metric	Target	Latest Date	Devon Value	Variation	Assurance
Primary care	Access to General Practice: Increase in clinical team appointments on pre-pandemic levels (per working day)	4%	2022-11	6.25%		
	Access to General Practice: appointments occur within 2 weeks of being booked	85%	2022-11	82.9%		
	Access to General Practice: general practice appointments occur within 1 working day of request	35%	2022-11	48.9%		
	Technology enabling access: Number of online/video consultations against target	50000	2022-12	52158		

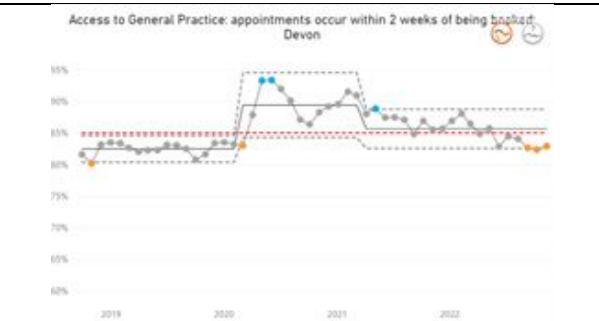
Data

Analytical summary

Analytical Commentary:
The target to increase appointments on pre-pandemic levels shows common cause variation and will not currently consistently meet the target.
The target of 85% of appointments in 2 weeks is showing special cause variation of a concerning nature and is not consistently achieving target.
The target of achieving 35% of appointments within 1 working day of request is showing special cause variation, however, is above target and consistently passing.

Operational Summary:
Increase in clinical team appointments of 4% on pre-pandemic levels carries the highest risk of not maintaining current performance. However, November achievement of 6.3% remains above target. During November, Devon GP Teams provided a higher level of appointments per 1,000 people than any other ICS in the Southwest region. GP team access has been further improved through ICB investment in additional GP team capacity through winter, including ringfenced funding to provide dedicated Acute Respiratory Infection (ARI) management.

Achieving 85% appointments within 2 weeks has been close to target for the last few months and is currently at 82.9% in November and an improvement from October. The main barrier to achievement remains continued high pressure on practices for urgent/same day need, which is exacerbated during the winter months. This focus on urgent need is supported by the ICB.



System GPAS/OPEL rating during December recorded a record number of 'black' returns from practices under severe pressure (by late December the overall system moved into critical incident). The number of 'black' returns has reduced during January, which is thought to be related to numbers of staff returning from sickness related or planned absences. However, the volume of practices declaring a 'red' alert state remains significantly high. Very high levels of demand continue to be reported.

The target of 35% of appointments occurring within 1 working day of request is achieving and the position has improved marginally since last month.

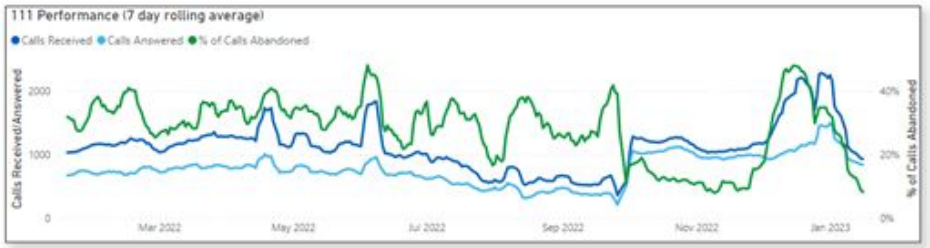
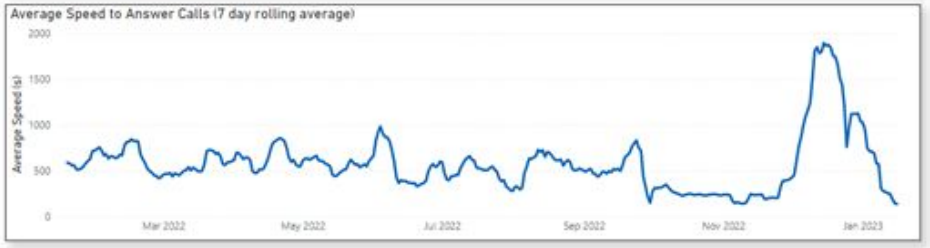
Number of online/video consultations against target: November 69,576, December 52,158. During the first 9 months of the financial year 2022/23, 480,646 online/video consultations have taken place and the ICS is on trajectory to meet the required target of 600,000 a year.

Workforce metrics	**Dec-22**
General Practice able to offer improved multi-disciplinary care through employment of 12 WTE additional roles (ARRS) per PCN by March 2023	An increase in PCNs has been achieved since last month and now 24/31 PCNs have more than 12 WTE ARRS
Achieve upper quartile performance in terms of WTE GP per 1,000 population	Devon ranked 4th highest of all ICSs

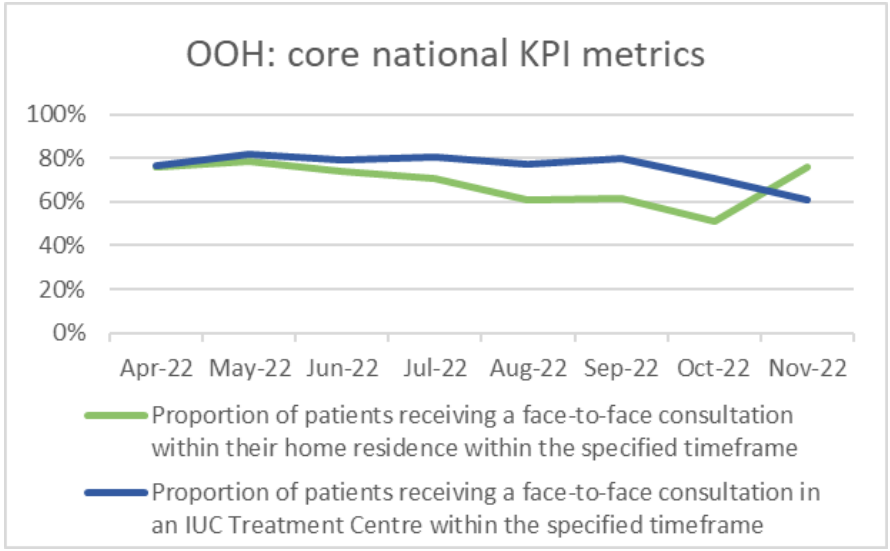
GP ARRS – the Primary Care Team continues to encourage PCNs to reach the target aim of 12 WTE ARRS staff (per PCN) by March 2023. Devon ICB has been able to support all bids submitted for use of ARRS underspend in Devon, equating to a further 19 WTE roles across the system to be employed this year in addition to those already recruited.

Devon has the highest GP number per 10,000 patients in the Southwest and is ranked 4th highest of all ICSs. GPs in training up 51%, increasing from August 2019 to August 2022 resulting in an additional 55 GPs in post.

Integrated Urgent Care Service: NHS 111

Data	Introduction
 	NHS 111 is part of the Integrated Urgent Care Service provided by Practice Plus Group (PPG) since 27 September 2022 following a competitive tender process.
	Analytical summary
	111 services across the country have seen unprecedented levels of demand during December. Activity usually increases over the Christmas, however, demand due to Strep A concerns resulted in over 60,000 calls being received by 111 services in Devon during December. An increase of almost 90% in comparison to the previous month. As with many providers, PPG were unable to answer all calls therefore the performance of abandoned calls fell significantly. However, PPG were able to answer many calls with over 11,000 more calls were answered compared to December 2021. Given the volume of calls received, the average speed to answer increased significantly in December with the average call taking around 20 minutes to answer. Average call answering time has reduced significantly since and in mid-January fell to less than 3 minutes.

Integrated Urgent Care Service: Out Of Hours

Data	Analytical summary
	Key performance standards for the Out Of Hours (OOH) service include patients who receive telephone advice or have their call triaged within a clinically defined timeframe and patients who receive a 'face to face' appointment, either within their home or at a treatment centre within a clinically defined timeframe. Securing clinical resource remains challenging and directly impacts on performance. PPG are working hard to encourage local clinicians to work shifts in the IUCS, but low pick-up rates are due to a number of reasons including competing demand on a limited workforce and higher rates of pay in other areas. As well as patients, the impact of reduced OOH capacity impacts on other NHS service providers in Devon including hospitals and general practice. Understanding what the “right” level of face-to-face treatment remains a difficult idea to establish. Whilst the levels of expected population demand (calls to 111) can be modelled with some confidence based on historic patterns of calls, interventions further down the patient journey are impacted by the model of working of the provider and a significant number of other variables. Within the next month, commissioners will receive a detailed contractual and performance information update from PPG for the first quarter of the contract. This will provide a solid base line from which to review and discuss with PPG the OOH element of the service.

Mental Health: System Overview

Metrics

Scorecard *(*Not updated since July 2022 due to CareNotes outage)*

Key Performance Indicator	National Target	System Target	Actual	Variation	Assurance
*Discharges followed up within 72 hours	80%	80%	81.19%		
*Community Mental Health access (2+ contacts)	18,942 Q4	17,452 Q4	16,360		
*Children & Young People's Access (1+ contacts)	14,037 Q4	13,477 Q4	12,200		
*Children & Young People Eating Disorders routine cases	95% Q1	95% Q4	49.5%		
*Children & Young People Eating Disorders urgent cases	95% Q1	95% Q3	85%		
Dementia Diagnosis Rate	66.7% Q4	60% Q4	54.95%		
*Early Intervention in psychosis (EIP): % entering treatment within two weeks	60%	60%	72.3%		
IAPT Access	9,383 Q4	7,716 Q3	6,033		
IAPT – first appointment within 6 weeks	75%	75%	94.68%		
IAPT – first appointment within 18 weeks	95%	95%	99.8%		
IAPT Recovery	50%	50%	52.4%		
*Individual Placement and Support (IPS) access	300 Q1 954 Q4	642 Q4	397	N/A	N/A
*Perinatal Access Rate	1,115 Q4	1,028 Q4	953		
Physical health checks for people with severe mental illness (SMI)	7,448 60%	7,448 60% Q3	4,446		
*Inappropriate out of area bed days (monthly)	0 Q4	0 Q4	479		
Annual health checks for people with a learning disability	75%	-	27%	N/A	N/A
Reducing adults and CYP with LD in specialist inpatient beds	31	-	40		
Workforce Vacancy Rate %			5.85%		N/A
Workforce Sickness Absence %		5.29%	6.65%	N/A	N/A

System Summaries

IAPT appointments offered within 6 and 18 weeks continue to perform consistently well and exceed the targets despite a slight decline in performance. However, IAPT Access has shown a decline in performance and is now experiencing special cause concern.

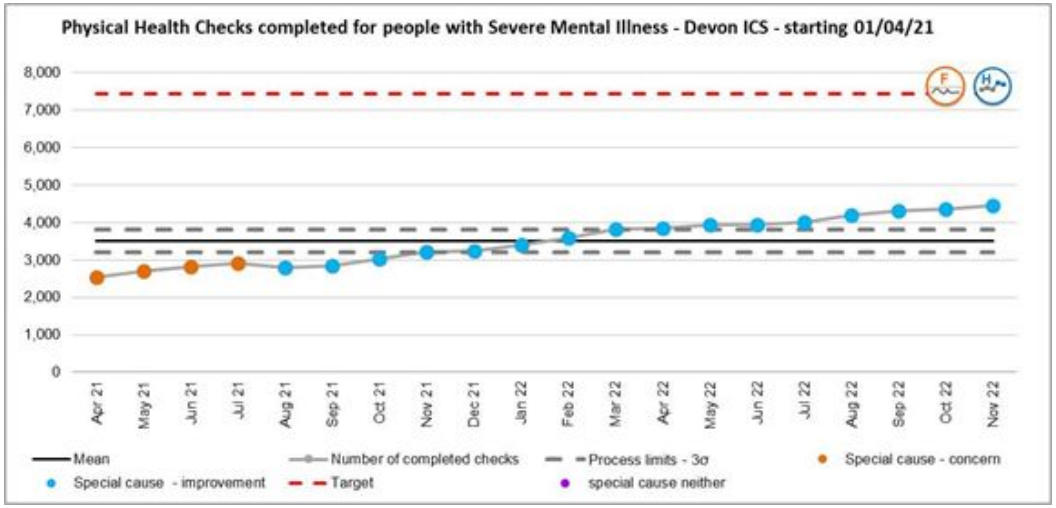
Physical health checks for people with severe mental illness (SMI) has seen an improvement in performance.

The dementia diagnosis rate continues to experience special cause variation of a concerning nature.

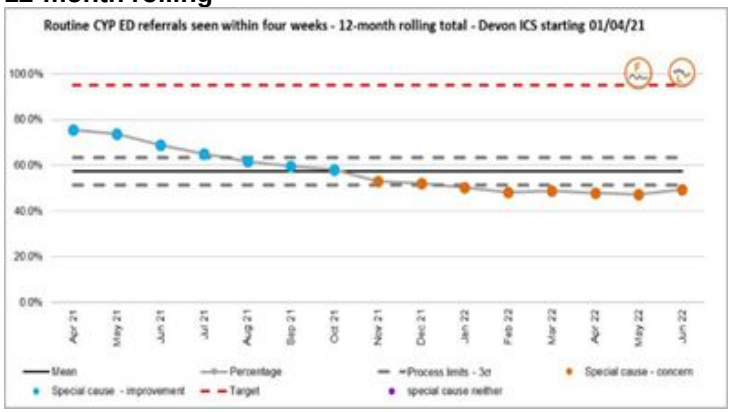
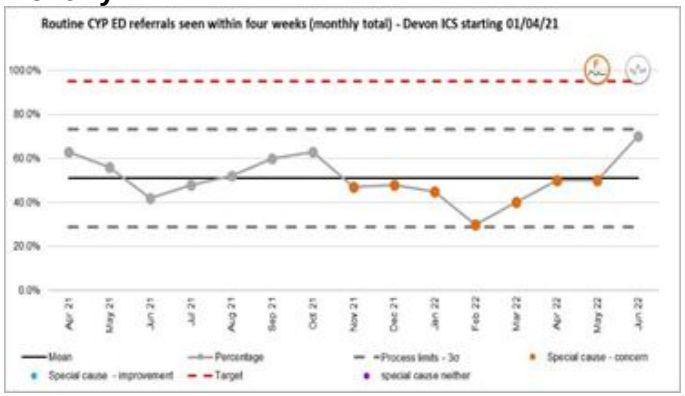
Carenotes is now operational. However, the substantial duration of the national outage and the associated gap in reporting information is expected to have an ongoing impact on reporting for up to a year (in some cases); from the point at which business as usual functionality is restored.

The metrics not impacted by the Carenotes outage relate to IAPT, dementia diagnosis rate, health checks for people with SMI and LD, the number of people with LD in inpatient care, and workforce.

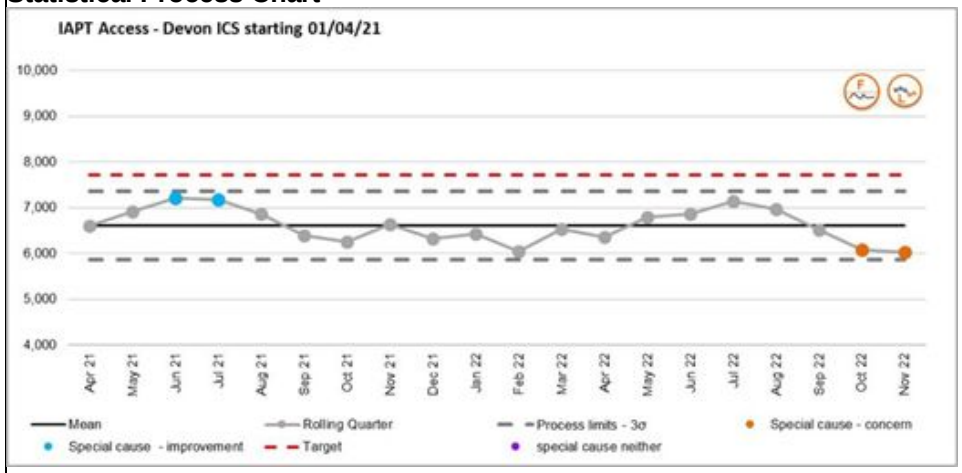
Mental Health: Severe Mental Illness – Physical Health Checks

Data	Summary
KPI Description NHS England Long-Term Plan deliverable that 60% (n= 7,748) of people on the General Practice list of patients with severe mental illness would have a complete physical health check in the last 12 months.  Data Source: GDPPR dataset, NHS Digital	**Analytical Commentary** The measure is showing special cause of an improving nature but is consistently failing the target. **Operational Summary** Uptake of health checks completed continues to increase with November 2022 at 43.17% (4,446/10,529). Devon has set a trajectory to achieve the deliverable of 60% by the end of March 2023 which would require 16.83% improvement in performance in the next 4 months. **Actions and Assurance** • NHS Devon continues working to fully mobilise the additional VCSE sector capacity which has been commissioned to help more people with severe mental illness access physical health checks. • Workstream developing a delivery model that will support physical health checks, with coproduction at its core. • Working with primary care through Webinars and other communications to promote uptake of additional capacity.

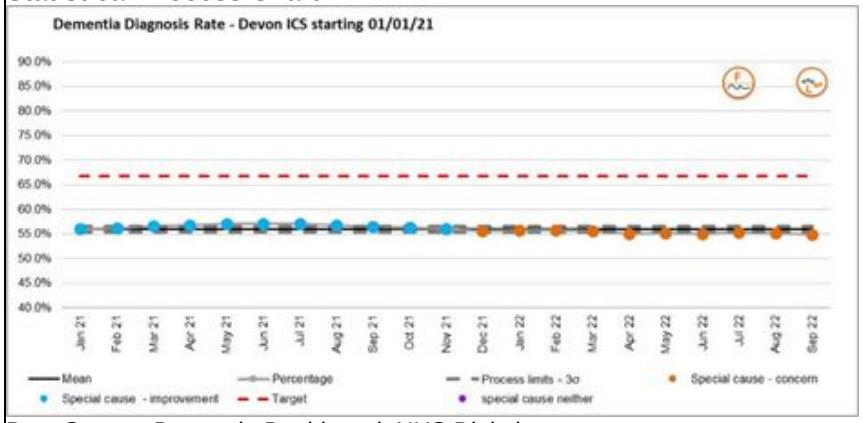
Mental Health: CYP Eating Disorders Routine

Data	Summary
KPI Description: The proportion of CYP with routine eating disorders that wait 4 weeks or less from referral to start of NICE approved treatment. Rolling 12-month target. **12-month rolling**  **Monthly**  ***** Data unavailable at system level after June-22 due to national patient records outtage. *****	**Analytical Commentary** This KPI was experiencing special cause variation of a concerning nature and will consistently fail the target without further intervention. Data is unavailable at system level after June 2022 due to national Carenotes outage. **Operational Summary** Across ICS Devon, planned actions relating to workforce and investment identified in the 2022/23 Operating Plan for Q3 have been implemented. Validated performance at provider level indicates that in Plymouth the trajectory was progressing towards the Q3 agreed recovery position. In December 2022 Covid had a significant impact on the workforce which resulted in reduced activity. **Actions and Assurance** In Q4, Devon ICS will continue to implement learning from the needs based review. In Plymouth, following the impact of Covid on the team in December 2022 additional support has been put in place to recover activity as quickly as possible.

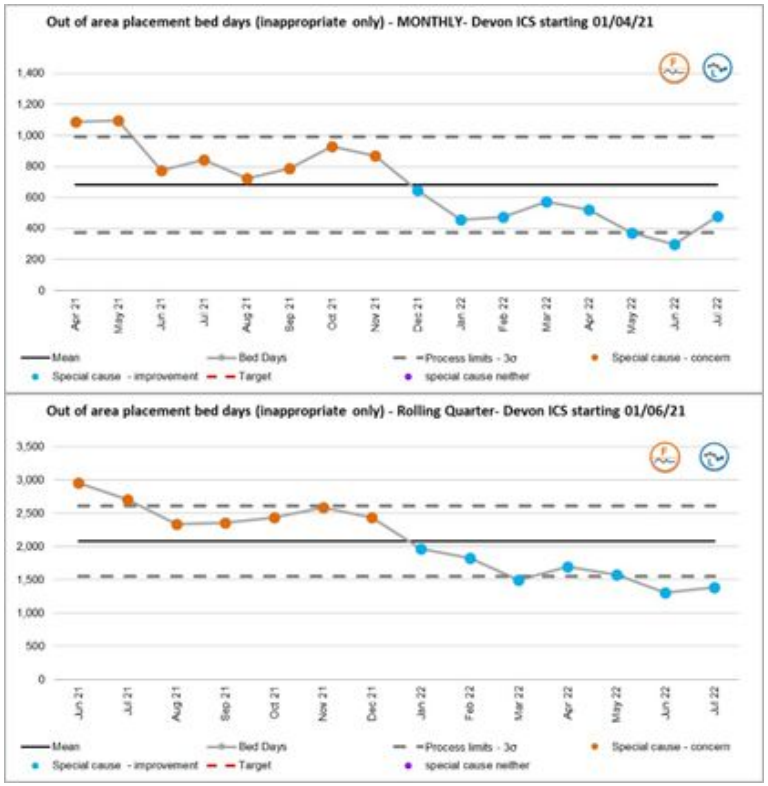
Mental Health: IAPT Access

Data	Summary
KPI Description The number of people who enter NHS funded treatment with IAPT services in the reporting period. Total is by rolling quarter. **Statistical Process Chart**  Data Source: Local data	**Analytical Commentary** The KPI shows common cause variation, but the last two data points show a statistically concerning position. Data shows this process is not capable of meeting the target and will fail without further intervention. The KPI is falling short of the Q3 target (7,716). **Operational Summary** Devon performance is not improving and despite public awareness campaigns recovery to achieve the planned target continues. Underachievement is not isolated to Devon. As of September 2022, performance against planned monthly access is 77.0% nationally, 68.9% regionally, 76.8% in Devon. Across Devon the planned actions identified in the 2022/23 Operating Plan for Q3 have been delivered, including: - promoting IAPT to the public and referrers. - developing IAPT Long Term Conditions offer in Plymouth. - enabling access through the Devon Staff Wellbeing Hub. - supporting access to help via the long-Covid pathway. Despite not meeting required access numbers, IAPT continues to achieve national access times. **Actions and Assurance** In Q3 a review of psychological therapy offers in Devon was completed, recommendations are being finalised for implementation in 2023/24,

Mental Health: Dementia Diagnosis Rate

Data	Summary
KPI Description: The proportion of estimated over 65s in the population with dementia that have been diagnosed. **Statistical Process Chart**  Data Source: Dementia Dashboard, NHS Digital	**Analytical Commentary** Performance since December 2021 shows a statistically concerning position and will continue to fail without further intervention. Devon's performance has been between 55% and 58% since April 2022. Nationally, performance has remained static at 62% since April 2021. There will be a national temporary suspension of the NHS Digital publication of this metric until April 2023. When the publication resumes in April 2023 all data will be back dated. **Operational Summary** Across Devon this metric is being supported by ongoing work with Primary Care to identify sustainable improvements in the support, care, and treatment of people with dementia in ICS Devon. Post diagnostic support for dementia is currently a risk, given joint NHS and Local Authority funding for those services which is not yet resolved for 2023/24. **Actions and Assurance** - Devon Executives have met to discuss the risk associated with funding of post diagnostic dementia support with a view to resolving this in January 2023. - A mandate for Older People's Mental Health/ Dementia will be drafted for the MHLDN Provider Collaborative Senate in February 2023.

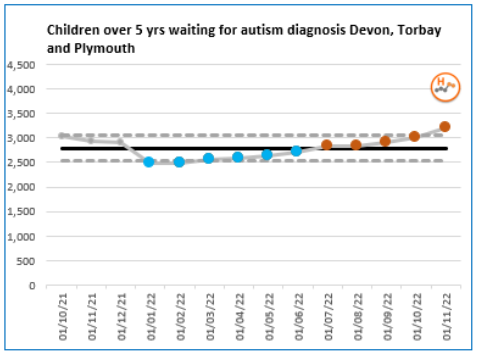
Mental Health: Out of Area Placements/Bed days

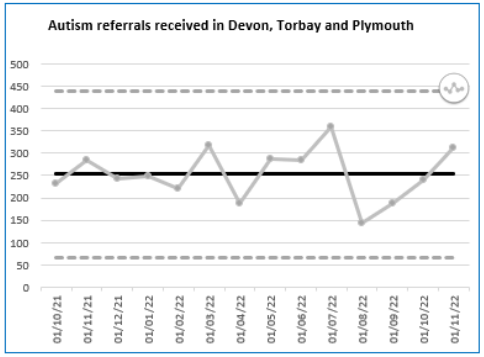
Data	Summary
KPI Description: The total number of days in which patients have been placed out of area due to unavailable beds in their usual network. **Statistical Process Chart**  ***** Data is unavailable at system level beyond June-2022 due to national electronic patient records outage. ***** Data Source: Monthly inappropriate OAPs stocktake	**Analytical Commentary** The measure shows special cause improvement with a run of eight points below the mean and close to the lower process limit, thus demonstrating consistent progress as of the last available data reported in July 2022. Data is unavailable at system level after July 2022 due to national Carenotes outage. Nationally and across the Southwest mental health provision is experiencing increased pressure in bed-based care. The ongoing impact of Covid and increasing pressure across the Southwest will impact upon progress against the planned trajectory. **Operational Summary** Devon continues to make significant progress against this ambition, fully delivering the planned actions in Q3 and reducing the number of people placed inappropriately out of area. **Actions and Assurance** Additional investment is being delivered to bolster capacity and manage increased demand for inpatient care in the winter period.

Children & Young People (CYP): Autism Diagnosis waiting times

Key Performance Indicator	Target/ Plan	Latest Period	Actual (system average)	Variation	Assurance
Autism Diagnosis (Waiting)	<18 weeks.	Nov 2022	76.8 weeks (Devon & Torbay 74.3 / Plymouth 79.3 weeks)	H	F

KPI Description
NICE guidance for CYP to be seen within 18 weeks from referral to start of assessment.
Devon, Torbay and Plymouth





Operational Summary – Devon, Torbay & Plymouth

What are the causes?

Legacy high levels of numbers of children waiting. Referrals are within common cause variation, although increasing over the last 3 months. Staffing establishment not sufficient to meet the demand and also clear wait list. Staffing vacancies in CFHD establishment with capacity currently at 63.5% budgeted clinical capacity.

Despite continuous recruitment campaigns there has not been enough interest in posts or applicants not having necessary skills and competencies.

TSDFT - 251 under 5's waiting up to 13 months for an appointment. 799 over 5's waiting as long as 21 months for an appointment. Assessments show 40% of over 5's are referred for neurodiversity.

UHP Community Paediatric wait is up to 48 weeks. If further assessment is required: Pre-school wait is an additional 54 weeks and School-age 78 weeks. Higher referrals noted at end of school terms.

8.3% cancelled clinics in December in CFHD – this includes cancellation by both families and service (system is being put in place to identify and report on data in more detail).

Actions

Review of waiting lists between CFHD community autism service and those held within TSDFT Community Paediatrics as well as reviewing the referral process end to end to identify improvements and ensure children are seeing the most appropriate clinician.

As part of First Steps/Next steps pilot - joint first appointment between TSDFT & CFHD staff has taken place and now planning fortnightly joint clinics.

Key worker – urgent discussion with LAs to take place, to pilot the wider role for key workers as part of the neurodiversity diagnostic pathway. 12 month non recurrent funding from Provider Collaborative. This will support the pre-diagnostic assessment elements of the pathway with expected medium term impact.

Joint clinics between CFHD & TSDFT reduces clinic time, need for follow ups and impact on long waiters

When is improvement expected?

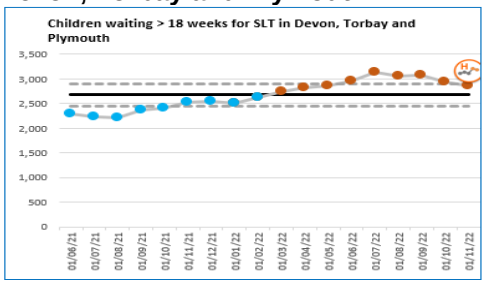
Trajectories have been submitted for Devon SEND WSOA and separately the Torbay SEND WSOA. The Devon trajectory is off target - December target was 1941 children waiting for assessment whereas actual referals in November 2022 increased the list to **2147**. Improvement is not expected until staffing levels increase and positive outcomes are achieved from the key worker pilot and joint working proposal.

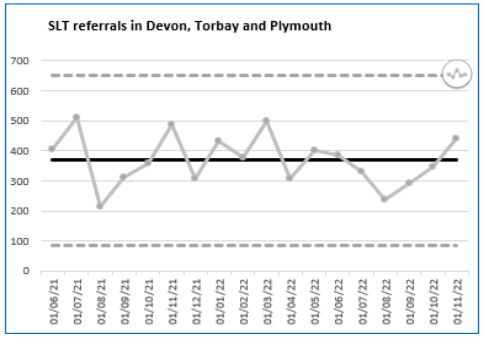
Children & Young People (CYP): Speech & Language waiting times

Key Performance Indicator	Target/Plan	Latest Period	Actual	Variation	Assurance
Speech and Language waiting times	< 18 weeks	Nov 2022	31.65 weeks (average). 104.5 weeks (longest wait).	H	F

KPI Description: NICE guidance for CYP to be seen within 18 weeks from referral.

Devon, Torbay and Plymouth





Analytical Summary
Referrals are within expected common cause variance and are lower than the same period last year.
The number of children waiting is reducing, however the metric is still in a concerning position.

Operational Summary – Devon, Torbay and Plymouth
Continued workforce vacancies reduces clinical capacity and applicants for posts have reduced.
CFHD's current vacancy rate in SLT is 36%.
Increased "Requests for Help" at Getting Advice and Getting Help stage takes SLTs away from clinical work and completing assessments.

What are the actions/what are the challenges*?*
Meetings held between Livewell and UHP to discuss issues of staff competency and training needed for dysphagia and working on pathway gaps for babies following discharge to community.
Wider pathway redesign within Devon and Torbay is dependent on the completion of CFHD staff consultation and implementation. To be shared with ICB late February/March 2023.
Workshop agreed early March between ICB and CFHD to review service prioritisation and levels of staffing investment required to meet service specfications as well as responses to changes in demand.

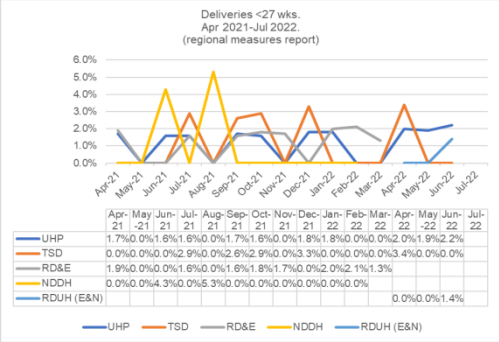
When is improvement expected*?*
LSW have agreed to over-recruit by 4WTE therapists to support the recovery of the service to pre pandemic levels, this will take 24 months once appointed.
The 12 week pathway is supported by the Care Aims Approach and Therapy Out Come Measures (TOMS) which continue to show good outcomes for children. In Plymouth - 529 currently waiting >18weeks (this has remains constant).
DCC funding agreed with CFHD, additional staff recruited (focusing on longest waiters) and 12 month action plan to monitor performance. Trajectory to reach RTT <18 weeks for Devon by March 2024.

Local Maternity & Neonatal System: Born in the Right Place

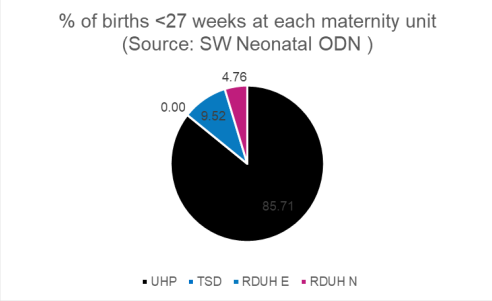
Key Performance Indicator	Target/Plan	Actual
% babies born in a maternity unit with an onsite NICU	>85%	85.71%

Latest Period: June 2022 Q1 & Q2

KPI Description:



85% of births at less than 27 weeks must take place in a maternity unit with an onsite neonatal intensive care unit



Operational Summary

Devon is meeting the required target of 85% of births at <27 weeks in a maternity unit with an onsite NICU. Devon ICB monitor for any unexpected peaks in <27 week delivery data at sites without a NICU (TSD, RDUH). Incident reports are requested from the ODN to understand the cause. Current process to obtain these reports requires improvement.

What are the causes?
Unavoidable factors include presentation with imminent delivery. Avoidable factors include referral pathways, in utero transfer and receiving capacity.

What are the actions/what are the challenges?
Born in a NICU (Overseen by the SW Neonatal ODN)

- Implementation of the guidance document: Saving Babies Live Care Bundle v2
- Improve pathways for in utero transfer
- Evaluation of incident reports where babies are not born in a NICU.
- Implementation of National care bundle to improve outcomes in preterm birth.

When is improvement expected?
All providers report compliance with Saving Babies Lives Care Bundle V2 survey (November 2022). Further embedding of these actions will support continuous improvement. Further improvements will be made in line with Saving Babies Lives Care Bundle V3 Publication is anticipated, but no date has been shared.
Continuous learning and improvement should be observed as a result of <27 week incident reports produced when transfers have not been made.

Actions
To strengthen LMNS oversight of babies not born in a NICU

- engage with the SW Neonatal ODN to understand causes of births without NICUs
- implement a robust route to obtain ODN incident reports on babies born in the wrong place to ensure learning is shared through the Safety & Governance Group, in line with the Perinatal Quality Surveillance Model
- To support trusts to obtain funding to support preterm birth reduction models/ preterm birth clinics.

Quality

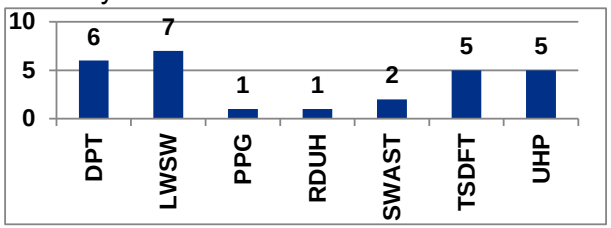
Quality Metrics

	Metric	Latest Date	System	Other providers	Royal Devon University NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospitals Plymouth NHS Trust
Quality	C-Diff	2022-12	18		4	1	4
	MRSA	2022-12	4		1	0	1
	MSSA	2022-12	29		5	2	7
	E. coli	2022-12	64		13	2	8
	Klebsiella	2022-12	19		5	1	2
	Pseudomonas spp	2022-12	3		0	1	0
	SAFETY SYSTEMS: SIs within elective, planned care	2022-12	0		0	0	0
	SAFETY SYSTEMS: SIs within elective, planned care (solely as a result of capacity)	2022-12	0		0	0	
	SAFETY SYSTEMS: Total number of Open Incidents	2022-12	295	169	35	38	53
	SAFETY SYSTEMS: Total number of Open Serious Incidents DEATH ONLY	2022-12	2		1	0	1
	SAFETY SYSTEMS: Number of SI's that are overdue	2022-12	157	100	25	22	10
	SAFETY SYSTEMS: Number of Never events	2022-12	1		0	0	1
	Patient Experience: Number of open formal complaints	2022-12	0		0	0	0
	Patient Experience: Formal complaints in relation to planned elective care	2022-12	0		0	0	
	Patient Experience: Provider concerns in relation to planned elective care	2022-12	0		0	0	0
	CIC: Average % of IHAs completed within statutory timescales	2022-12	47%				
	CIC: Average % of RHAs completed within statutory timescales	2022-12	55%				
	Safeguarding Adults: S42.2 enquiries relating to care provided by services commissi...	2022-12	5				

Serious Incidents

Serious Incidents received by Provider

During December 2022 there have been **27 serious incidents** reports, these are broken down by Provider in the chart below:



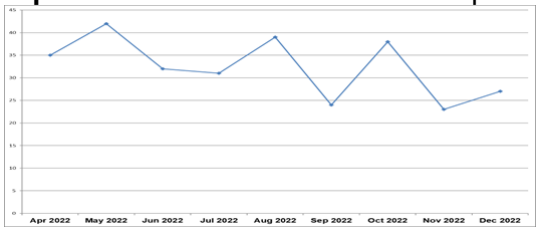
There was 1 Never Event reported in December 2022. Since April 2022 there have been **16 never events reported**, which is an increase compared to the same period last year (10).

The **top five Serious incident** types reported in December 2022 were*:

Pressure Ulcer (3) ↑
Slips/trips/falls (3) ↓
Diagnostic Incident (2) ↑
Apparent/actual/suspected self-inflicted harm (10) ↑
Treatment delay (5) ↑

**the arrow indicates change from previous month*

The below chart shows the total number of **reported serious incidents** since April**:**



Total number of **open incidents** for the system in December is **295**.

Overdue Investigations

The total number of **overdue investigation reports** that have not yet been completed and submitted to the ICB remains a concern for the ICB. The numbers remain stable across all providers. The safety systems team are continuing to provide support to all providers in reducing their overdue incidents.

The **total number of overdue** incidents for the system in December was **157**.

There are currently **15 open serious incidents** that have been identified as **multi-agency**. These are being investigated jointly to help improve identify what went wrong throughout the patient's care leading up to the incident. This also enables joint learning across Providers.

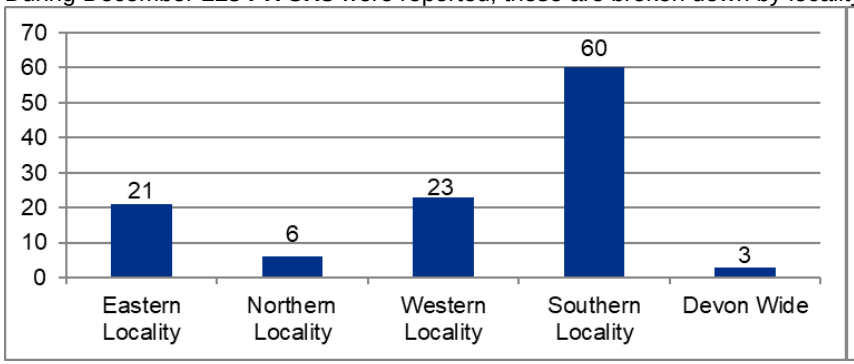
The SI reviewers within NHS Devon are also monitored with a 10 day KPI. There are currently **16 incidents being reviewed** which are currently being monitored by the SST to meet the deadline.

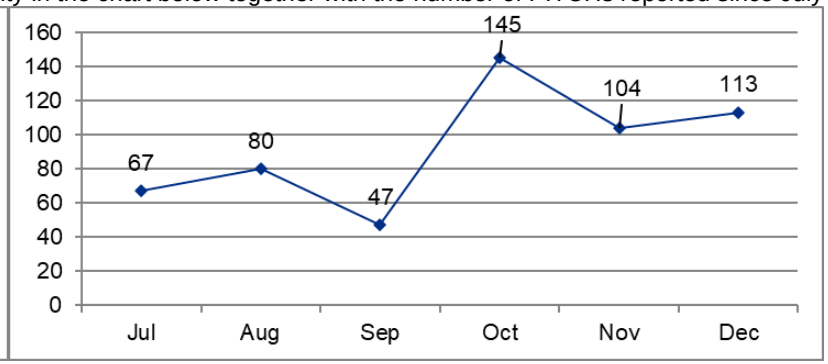
During December **30 incidents** were reviewed and assurance received for **closure**.

Peer Improvement Tips for Care and Health (PITCH)

Data

During December **113 PITCHs** were reported, these are broken down by locality in the chart below together with the number of PITCHs reported since July 2022:

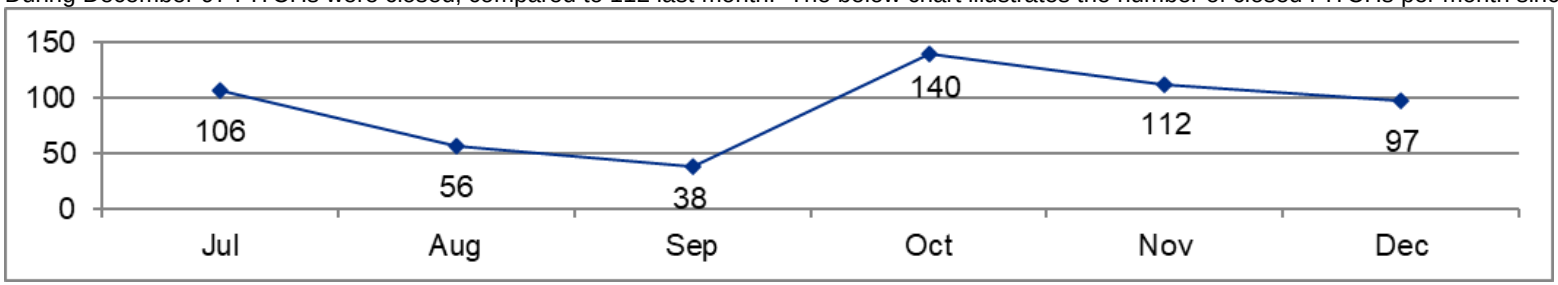




The **top three PITCH concerns received in** December were: Access to Services (29), Referrals (21) and Procedure or process (20)
There has been continued high reporting relating to out of hours access, in particular long wait times for call backs from clinicians and delays in verification of death in the community. Other key themes that have been identified are incorrect referrals to MIUs/UTCs from both primary care and 111, and patients being discharged from hospital without adequate medication supplies, leading to workload shift into primary care.

Closed PITCHs

During December 97 PITCHs were closed, compared to 112 last month. The below chart illustrates the number of closed PITCHs per month since July 2022:

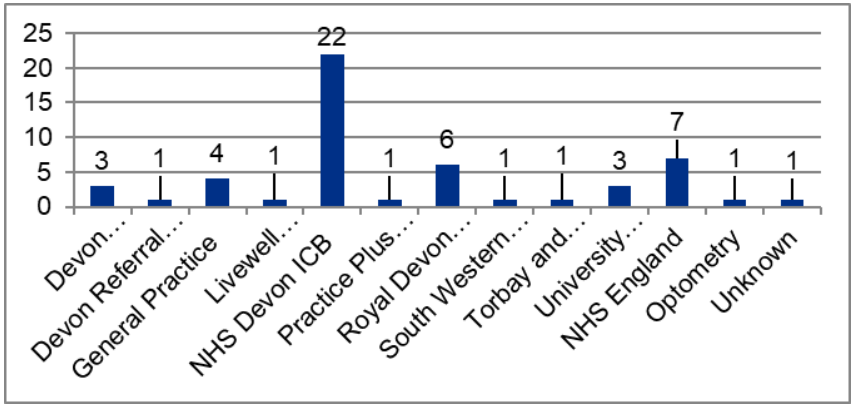


- 79 PITCHs remain open

Patient Experience (NHS Devon): Patient Contacts

Patient Experience Reports - November

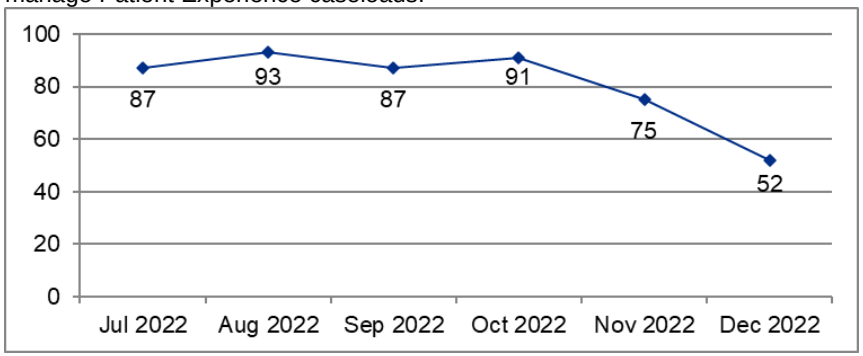
During December there were **52 new patient experience** feedback and concerns to manage, these are broken down by Provider in the graph below:



Continued contact relating to ADHD/Autism services, particularly care after 'right to choose'. Previous contact related to adult services, there is also increased contact relating to children services. We have also received a number of complaints about the 111 service

Patient Experience – Informal Concerns

Patient experience informal concerns have reduced in the past few months, with 52 concerns being received in December. This is lower than the 2022's monthly average of 84 concerns being received. Closures continue to decline in line with the falling contacts in November and December. The previously higher closures in September and October were linked to improved processed to manage Patient Experience caseloads.

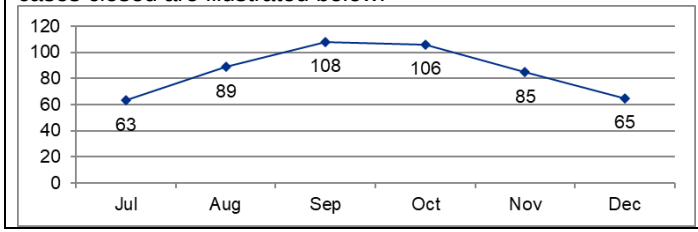


The **top three patient experience concerns received in** in October were:

- Quality of Care **(22)**
- Procedure and Process **(15)**
- Access to Services **(11)**

Patient Experience – Closed cases

The **closing** of patient experience concerns has reduced however this is reflected in the volume of new contacts demonstrated above. The number of cases closed are illustrated below:



Patient Experience Summary

- There were **no formal complaints** raised during December for NHS Devon.
- There have been **4 contractual reviews received** and in progress, which are required and form part of Primary Care complaints which are managed by NHS England.
- There were **2 new requests for information** from the **Parliamentary Health Care Ombudsman (PHSO)**

Safeguarding: Adult Enquiries

Issue: Safeguarding Adult Enquiries (Section 42.2) are undertaken when concerns about abuse and neglect within health care settings are raised. The statistics below are in relation to the new S42.2 enquiries caused out by the 3 local authorities in Devon for December 2022 and the primary themes of the concerns.

Data				Underlying cause
	October	November	December	**Themes:** The top issues identified within new S42.2 enquiries started in December 2022 related to: • people in a position of trust either within a healthcare setting or non-work settings (four) • discharge from an acute setting (one)
Total number of S42.2 enquiries	⬆ 10	⬌ 10	⬇ 5	

Initial learning from new safeguarding enquiries, closed safeguarding enquiries and safeguarding adult reviews:	Assurance
Initial learning regarding people in a position of trust relates to the need to be always professional and respect each patient's personal space.	The increase in reported allegations highlights an increased awareness of the need to raise concerns relating to professional practice.

Actions for next month/s	Intended impact	Date impact will be realised
Completing actions arising from safeguarding adult reviews undertaken by Torbay and Devon Safeguarding Adult Partnership (TDSAP).	Actions to improve care.	Action plan completion dates are monitored by TDSAP

Safeguarding: Children in Care (CIC)

Issue: Children entering care should receive an initial health assessment (IHA) within 20 working days of coming into care, and a review health assessment (RHA) should be undertaken 6 monthly for the under 5s and annually for over 5s.

Underlying cause

The inconsistencies in provider reporting across the system, means that we are unable to provide an accurate or consistent data set. This is coupled with late notifications and requests for health assessments by the local authorities.

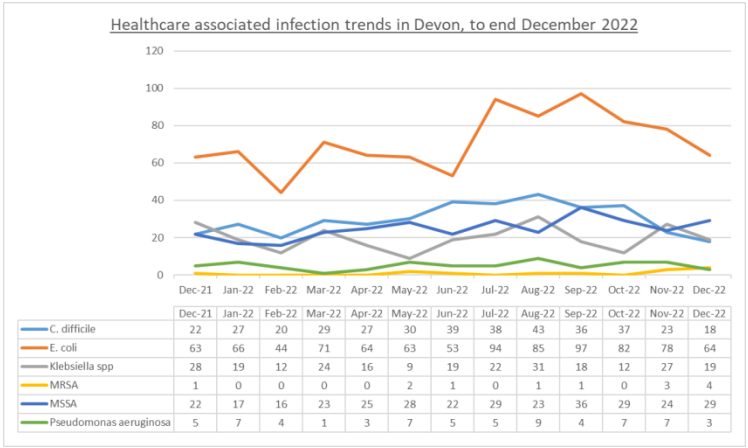
	System	TSDFT	RDUH - Eastern	RDUH - Northern	UHP	LIVEWELL	CFHD
Percentage of CIC receiving RHA's within statutory timescales (this is 6 monthly for U5s and annually for Over 5s)	**58/105** **55%**					**27/39** **63%**	**31/66** **51%**
Percentage of CIC receiving IHA's within statutory timeframe of 20 working days of coming into care.	**9/19** **47%**	**4/7** **57%**	**No data submitted**	**1/3** **33%**	**4/9** **44%**		

Actions undertaken in last month	Impact

1. Ongoing meetings with the three LAs to improve notification process. 2. Designated Doctors have devised a spreadsheet that all Named Doctors can complete monthly. Aim to launch in January 2023 3. Revised Outcome Framework developed to improve consistent reporting of RHA activity. 4. Recruitment of additional medical resource commenced. 5. Partnership working across health and social care to ensure that the health needs of unaccompanied young people are met.	Timely review health assessment requests are now sent to Livewell by Plymouth City Council which enables improved workforce planning. Consistent reporting will enable improvements to be made in the timeliness of health assessments. All young people will have the required screening in a timely way and health needs identified and met.

Actions for next month/s	Intended impact	Date impact will be realised
Named Doctors to use agreed spreadsheet to report IHA activity.	Consistent accurate data across Devon.	January 2023
Recruit to CIC Registrar post.	Increased medical capacity across the system	February 2023
Meet with commissioners to agreed outcome framework.	Implementation of more accurate KPIs across the provider teams in Devon	January 2023

Infection Prevention and Control

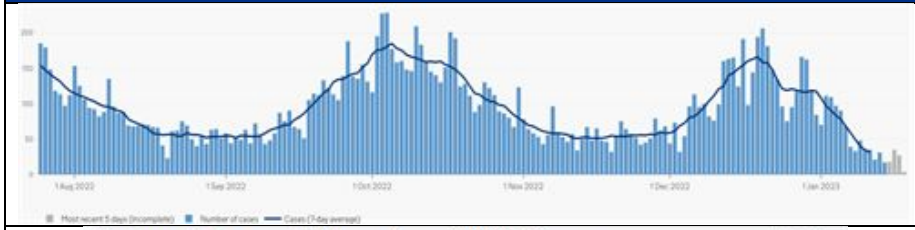
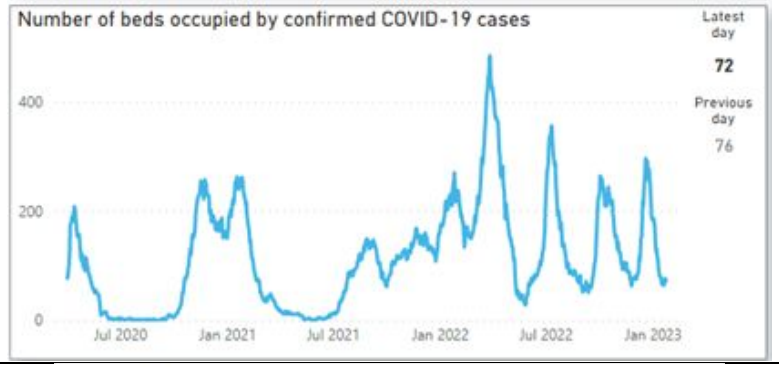
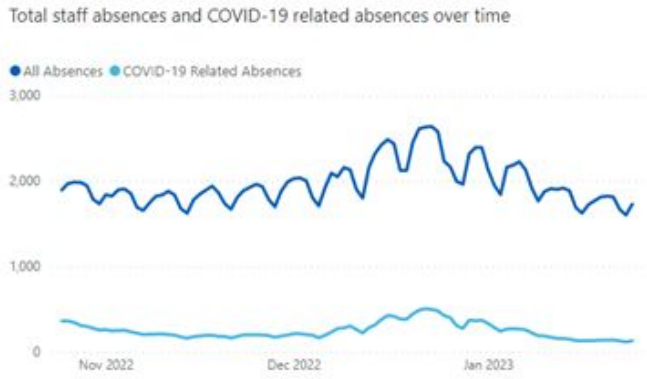
Data	Infection Highlights
	There has been system pressure over the holiday period, with all four acute trusts affected. A component of this pressure has been infection control, with trusts experiencing high volumes of seasonal influenza, COVID-19 and respiratory syncytial virus (RSV). Additional measures were required to improve hospital flow, and these were individually risk assessed as necessary. There has been a rise in MRSA cases over November 2022 (3) and December 2022 (4), with the majority of these being community-associated.
	Influenza (seasonal and avian)
	The vaccination programme for seasonal flu is continuing, with weekly monitoring meetings identifying emerging vaccine rollout issues. Communications are focusing on specific cohorts where there is poor vaccination uptake. A change of provider for antiviral prophylaxis has been finalised and is in place, with discussions ongoing regarding specific responsibility in and out of flu season.

	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
C. difficile	22	27	20	29	27	30	39	38	43	36	37	23	18
E. coli	63	66	44	71	64	63	53	94	85	97	82	78	64
Klebsiella spp	28	19	12	24	16	9	19	22	31	18	12	27	19
MRSA	1	0	0	0	0	2	1	0	1	1	0	3	4
MSSA	22	17	16	23	25	28	22	29	23	36	29	24	29
Pseudomonas aeruginosa	5	7	4	1	3	7	5	5	9	4	7	7	3

Actions undertaken in last month	Impact
Tuberculosis latent screening operational pathway	Operational guidance for tuberculosis professionals regarding latent screening in the context of asylum seeker and refugee need. This involves a temporary pause to latent screening, with active testing and contact tracing to remain in place.
Support to asylum seeker & refugee hotels	Improved health outcomes and reduced outbreaks in these settings.

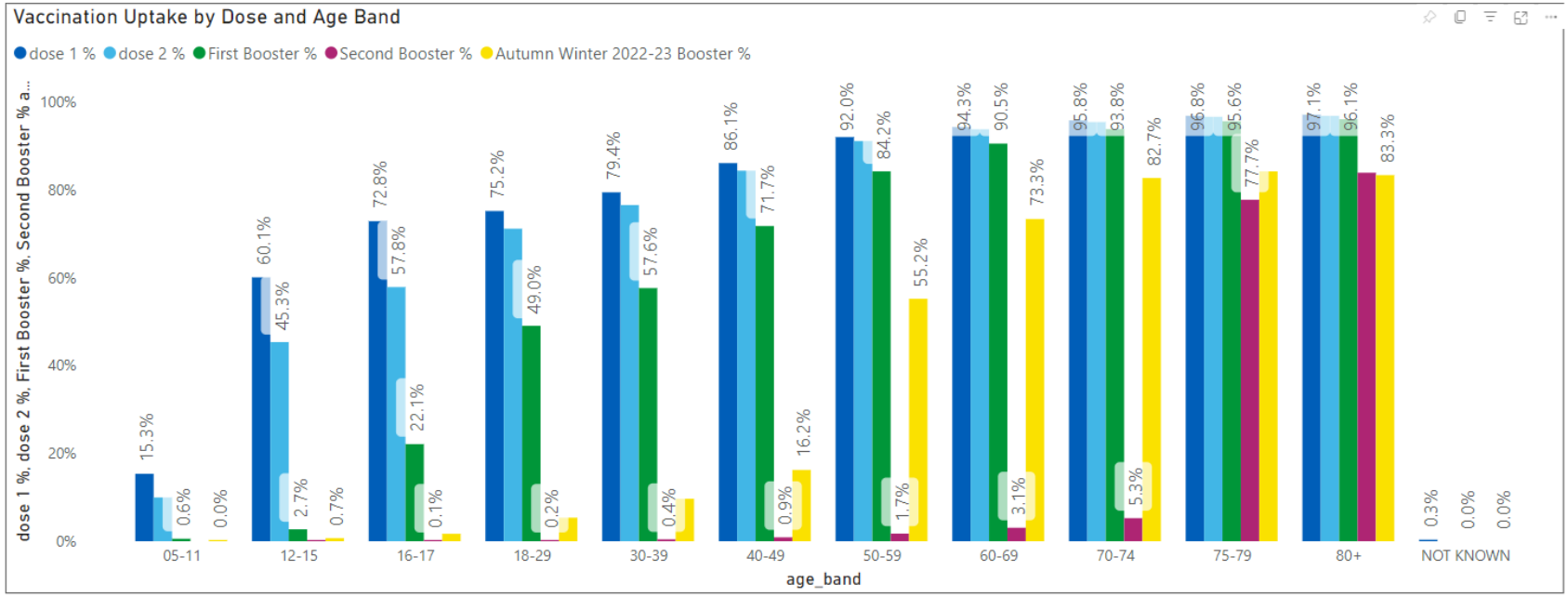
Actions for next month/s	Intended impact	Date impact will be realised
Infection control and antimicrobial resistance system meetings.	Sharing of good practice, dissemination of national requests and information, system assurance. Closer linking with Cornwall.	January 2023
Tuberculosis commissioning pathway evaluation.	Consistent provisioned service for tuberculosis, including video observed therapy and directly observed therapy.	February 2023
Gap Analysis/Action Plan tool completion and action plans in place to address identified gaps.	Regional and local assurance of outbreak systems in place.	February 2023

Covid Update

Data	Narrative
	Covid infections peaked again mid-December but fell in January 2023.
	The number of Covid patients in hospital beds has reduced from the most recent peak of 296 on the 24th December 2022 down to 72 on 24th January 2023. Covid patients in ICU continue to remain low. As of 24th January, there was 1 patient with Covid occupying an ICU bed in Devon.
	Total Covid-related absences have decreased at a steady rate since Christmas across all providers, reducing from 506 on 22nd December to 130 on the 24th January 2023 which is much lower than the 3%+ Covid absences seen during October and previous Covid peaks. Latest figures show 4.9% of staff are absent in total across Devon's providers on 24th of January, a reduction in the 7% position of a month earlier.

Covid Update: Vaccinations

Data



Narrative

The focus of the vaccination programme has been on boosters with good progress being made particularly for older age groups. Above 80% of over 70s, 73.3% of 60-70 year-olds and 55.2% of 50-60 year-olds have now received their Autumn/Winter booster. (all figures as of 24th January 2023)

Workforce

Workforce: Metrics

	Metric	Latest Date	System	Devon Partnership NHS Trust	Royal Devon University NHS Foundation Trust	Torbay and South Devon NHS Foundation Trust	University Hospital Plymouth NHS Trust
Workforce	WTE Current month against plan (Variance)	2022-11	-149	-54.9	22.3	Data unavailable	285
	WTE (Actual)	2022-11	32,185	3,656	12,284		9,686
	Medical/Dental Consultant Vacancy	2022-11	84.8	20.3	20.7		39.9
	Registered Nursing, Midwifery and Health Visiting St...	2022-11	363	144	251		8.84
	Allied health professionals Vacancy	2022-11	265	6.33	142		69.2
	Health care assistants and other support staff (Nursi...	2022-11	341	-53.2	207		98.0
	Agency spend	2022-11	4834	961	2236		470
	Total pay bill - substantive, bank agency spend	2022-11	133794	15278	50992		40653
	Agency spend as a % of pay bill	2022-11	3.61%	6.29%	4.39%		1.16%

- There remains an issue with reliable data with TSDFT which has been escalated. A date for resolution has not yet been identified.
- Across the system, there is an over recruitment to planned numbers by 149 WTE (0.47%).
- WTE numbers are included to provide context to the rest of the figures.
- DPT has a high proportion of consultant vacancies (MH) at 20%. The medical recruitment campaign and other initiatives aims to reduce vacancies by attracting and retaining more individuals within the system.
- DPT has the highest percentage nursing vacancy rate at 15.5%. Over investing in HCA workforce supports vacancy gaps in addition to international recruitment.
- RDUH has the highest AHP vacancy rate at 13%. The International Recruitment campaign is supporting recruitment to some of these vacancies.
- Agency spend is 3.32% of the total pay bill YTD. (*NB: figures above show in month spend and will be changed to YTD figures for forthcoming iterations*).
- £62.8M above planned year to date total workforce costs (year-end forecast, £90.4M overspend against plan). All programmes of work support spend reduction.
- All Trusts are using higher than planned agency and bank WTE and cost, £11.2M overspend year to date.

Workforce: Workforce Strategy

- **Strategic Workforce Planning:** An agreed specification for a Strategic Workforce Planning (SWP) tool has been developed which received approval for funding through HEE workforce development funding in January 2023. Business case approved in January 2023 and subject to approval the build of the SWP tool for the pilot phase will commence in Q1 FY 2023/24.

- **Workforce Strategy:** On track for completion of the written strategy by the end of March 2023 with a detailed numerical workforce plan by end of Q1 FY 2023/24. The numerical workforce plan will be informed by the completion by providers of a Self-Assessment Tool developed using the output of the workforce strategy development workshops. Assessing organisations' position in relation to their staffing headcount requirements to achieve the Workforce Vision.

Workforce: Learning, Education and Strategy

- **Placement Expansion:** baseline data being collected for placement capacity across the system. Provided data has not previously been collated and reliance on university placement portals have been the previous source. Data collation will be completed by 28th February 2023. Placement Expansion Plan for next 3 years will be available end of March 2023

- **Continuous Professional Development:** Health Education funding for 2023/24 CPD has not been announced and unlikely due to merger with NHS England. A CPD plan is being drafted and available end of March 2023

Workforce: Best Place to Work (BPTW)

- **Wellbeing Hub:** Discussions are ongoing following likely withdrawal of national funding from April 2023. Paper demonstrates current and potential service offer, utilisation, return on investment, counterfactual impact on staff wellbeing. Risk will be escalated to People and Culture Committee with Task and Finish Group to be stood up with immediate effect.

Workforce: Workforce Capacity

- **International recruitment (IR):** The Alliance continues to meet demand requirements, 701st Nurse deployed by the end of the year. Devon Alliance currently matching CW (Care Workers) CVs for 42 providers. The fifth Domiciliary Care worker arrives at Devon this week. 24 AHP Conditional Offers: 21 Diagnostic Radiotherapists and 3 Occupational Therapists. SWASFT campaign underway for 10 Triage Nurses.

- **Collaborative bank:** January meeting stood down while work undertaken by the external consultant to identify further savings, benchmarking and prioritisation.

- **Bank and agency spend:** Framework live from 1st November to help standardise rates and formalise the approach to agency tiering for Nursing. Continue to formulate plans to eradicate the use of non- framework agencies. Spending on Nursing off-framework beginning to reduce (November 2021 -£415.3K, November 2022 - £398.6k). Work is starting on the same approach for AHP rates.

- **Medical Recruitment Campaign:** 5/6 videos complete. Website live, marketing approach agreed. Some final amendments to content being made and planning to go live next week.

- **MOU:** MOU formally agreed via HRD's delayed due to some further comments from a Trust. Now planned for sign off in February 2023.

NHS Devon

NHS Devon Integrated care Board

Committee Chair Report – Quality and Performance Committee

Date of meeting	Date(s) of committees covered in this report
15 February 2023	1 February 2023

Chair	
Name and title:	Professor Hisham Khalil, Non-Executive Member

Reports discussed and assurances received

The Committee received update reports as detailed below:

Integrated Quality and Performance Report (IQPR).
Operationally in December the ICS remained under extreme pressure with increasing Covid / Flu inpatient numbers combined with an upturn in community infections placing pressure on primary care. This alongside industrial action in nursing and ambulance services has resulted in further extended delays in urgent care, ambulance conveyancing and waiting times, with a resultant impact to patient care.

The Committee noted that the IQPR report does not demonstrate any significant change in position compared to the data presented in the previous month with the system facing significant challenges across multiple domains. Providers are now providing harm reports in relation to elective care patients with long waits. The elective care actions are being revised. The Committee also discussed the importance of accountability and the actions by the system when interventions are not having an effect.

Board Assurance Framework (BAF) Risk report
The report was discussed in relation to two strategic BAF risks that relate to the Corporate Objectives (3) Enable a greater shift from treatment to prevention (4) Deliver safe and effective urgent and emergency care services that better meet people's needs (5) Reduce the number of people waiting for elective are – with a specific short-term focus on 104-week waits.

Risk Description

BAF Risk 1: If the ICB is not proactive in its approach and priorities around population health management and prevention then it will not successfully drive the shift to prevention. This will impact on the system's ability to successfully target interventions at those groups most at risk, prevent ill-health and address health inequalities.

BAF Risk 2: If the system does not have robust recovery plans, that are continually monitored for impact, then the ICB will continually fail to ensure timely access to both elective and unplanned care. This will result in poor patient experience, failure to ensure the best possible physical and mental health outcomes and resulting quality of life; and loss of confidence from the community and regulators.

The Committee discussed the risks scores, controls, and assurances. There was a recognition that actions and mitigations will depend on the priorities of the operational plan for the coming year. The target of ensuring all patients waiting more than 78 weeks have a clinical review or clinical validation within 12 weeks of last review was discussed. Committee members highlighted the need for a clarification from the Board on this priority.

There was a discussion regarding the opportunity of enabling work in relation to the population health and prevention risk irrespective of the priorities of the operational plan for the coming year. The Committee members were keen to have sight/ discuss all the BAF risks and not just those allocated to the committee to have better insight into the working of the different committees and how they interact. This will be raised to the Board.

Reports received and noted

N/A

Committee Development Activity

The second part of the committee meeting was a development event facilitated by Tracey Cottam. The aim was to reflect on the work of the Committee over the last 7 months, review the terms of reference, enhance the effectiveness of the Quality and Performance Committee members working together and providing assurance to the Board. The activities included what worked well for the Committee in the last 7 months, what areas require improvement as well as the next steps/actions. There will be a thematic synthesis of the outputs of the event to be shared with

Committee members and with opportunities to have additional development meetings to enact the agreed actions.

Committee decisions

- N/A

Items of concern to be escalated to the board

- The Committee would like to discuss the target/recovery plans for patients waiting for more than 78 weeks at Board level.
- Discussion of the BAF risks allocated to the Committee and interaction with other committees

Recommendations for the board

- To consider the reports received and positions of assurance by the Quality and Performance committee

Recommendations for other committees

- Discussion of the outcomes of the Q&P Development Event with other committees for shared learning

Terms of reference or other committee effectiveness issues

- These will be discussed in the next Q&P Committee and following the development event.

NHS Devon Integrated Care Board

NHS Devon (ICB) Finance Report Month 9

Date of committee	Date report produced
15 February 2023	2 February 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	2 February 2023
Email:	kevin.wheller@nhs.net		

If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary
The presentation of the Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31st March 2023. This report details the ICB financial position as at 31st December 2022, setting out the year to date and forecast financial position.

Proud to be part of One Devon: NHS and CARE working with communities and local organisations to improve people's lives

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance Committee approved the report on the 1st February

Key recommendations and actions requested
The board is requested to: Consider, review and discuss the ICB financial position as at the period ended 31st December 2022.

Impact on NHS Devon objectives	
Objective	**Impact**
Make more efficient use of our resources	To enable the delivery of the ICB control total

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services		√
Health inequalities		√
Workforce		√
Resources and finance	Delivery of financial sustainability	
Legal		√
Engagement and consultation		√

NHS Devon has made every effort to ensure this report does not discriminate (directly or indirectly) against employees, patients, contractors, or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS Devon Integrated Care Board

Finance Report

Month 9 – 2022/23

Contents

Appendices

1. Executive Summary

The presentation of the Integrated Care Board's (ICBs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICB for the year ended 31st March 2023.

This report details the ICB financial position as at 31st December 2022.

On 20th June 2022, Devon Integrated Care System (ICS) submitted a deficit plan of £18.2m and an expectation that £138.9m of efficiency savings are needed to meet that plan. Within the that plan ICB's planned financial position is breakeven with a requirement to deliver £36.5m of efficiency savings

From 1st July 2022 NHS Devon CCG was dissolved and NHS Devon Integrated Care Board (ICB) was formed, requiring the CCG to produce a set of CCG accounts for the period 1st April to 30th June 2022. The first set of ICB accounts will be for 9 months, the period covering 1st July 2022 to 31st March 2023.

Throughout this report and in line with the plan the stated position is for the whole of 22/23 including the first 3 months.

Financial Position

The following detailed report reflects the budget set by the 2022/23 NHSE financial framework compared with the actual commitments against that budget for the period to 31st December 2022 and the year ending 31st March 2023.

As at 31 December 2022	Year to date				Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Total Net Expenditure	1,905,331	1,902,242	3,089	↑	2,542,819	2,546,254	(3,435)
Resource Allocation	(1,905,331)	(1,905,331)	0	→	(2,542,819)	(2,542,819)	0
Additional Roles Reimbursement Scheme	0	0	0	→	0	(8,070)	8,070
Total Commissioned Services	**0**	**(3,089)**	**3,089**	↑	**0**	**(4,635)**	**4,635**

Overall, subject to the ICB receiving the expected allocation from NHSE for the Additional Roles Reimbursement Scheme (ARRS) costs, we are reporting a YTD and FOT surplus of £3.1m and £4.6m respectively. The ARRS relates to primary care additional roles employed by Primary Care Networks that are funded centrally and reimbursed in arrears.

As reported and agreed at the previous finance committee the updated forecast surplus for the ICB sits within an overall amended forecast for the system of a £49.5m deficit. This represents a movement from a breakeven plan for the ICB which has been supported by NHS England within the overall system movement. The ICB surplus is as a direct result of regional support to achieve the agreed deficit position as a system.

Further discussions will take place within the system to identify how the ICB surplus may be distributed across system partners with any amendments made within the

Month 10 position. As this will be a net neutral change to the system it does not require further permission from NHS England.

As at month 9 some service lines are currently exceeding budget including some acute services, continuing healthcare, individual placements and primary care prescribing. These variances are currently being covered by contingencies set aside at plan to manage in year variation and held in reserves.

Service line variances are detailed in the sections 2 and appendix 3.

Savings Plan

The ICB's savings plan includes a saving requirement of £36.5m.

The delivery of savings and efficiencies is off plan at month 9 by £4.9m, driven by a slower than expected delivery of savings linked to placements and targets associated with the recovery programme.

Savings plans are forecast to deliver to target by 31st March 2023 and actions are being taken to improve the delivery going forward. More detail is provided in section 3.

Risk

The ICB has identified risk to delivering a breakeven position of £17.9m at 31st December 2022 including risks relating to delivery of the savings target and increases in prescription drug prices. Actions including release balance sheet flexibilities and use of non-recurrent funding streams have been identified that have fully mitigated the identified risk.

Conclusion

As at 31st December 2022 the ICB is reporting a forecast surplus of £4.6 against a breakeven plan. This is likely to change in Month 10 following system agreement on how this surplus might be distributed across system partners.

2. Detailed Financial Performance

The year to date and outturn by main service heading as at 31st December 2022 is as follows.

Service	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000		Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	
Acute	940,017	943,252	(3,235)	↓	1,253,956	1,257,693	(3,736)	↓
Mental Health	203,753	205,327	(1,574)	↓	271,711	274,739	(3,028)	↓
Community Health	229,179	229,854	(675)	↓	307,087	308,585	(1,498)	↓
Continuing Care	110,005	110,208	(203)	↓	146,684	146,795	(111)	↑
Primary Care	337,673	340,204	(2,531)	↑	450,235	462,477	(12,242)	↓
Other Programme	28,287	27,070	1,217	↓	37,758	36,952	806	↑
Total Commissioned Services	**1,848,914**	**1,855,915**	**(7,001)**	↓	**2,467,430**	**2,487,241**	**(19,810)**	↓
Running Costs	17,274	17,925	(651)	↓	22,919	22,919	(0)	→
Net Expenditure	**1,866,188**	**1,873,840**	**(7,652)**	↓	**2,490,349**	**2,510,160**	**(19,811)**	↓
Reserves/Contingencies	39,143	28,402	10,741	↑	52,470	36,094	16,376	↑
Total Net Expenditure	**1,905,331**	**1,902,242**	**3,089**	↑	**2,542,819**	**2,546,254**	**(3,435)**	↑
Resource Allocation	(1,905,331)	(1,905,331)	0	→	(2,542,819)	(2,542,819)	0	→
Additional Roles Reimbursement Scheme	0	0	0	→	0	(8,070)	8,070	→
Total Commissioned Services	**0**	**(3,089)**	**3,089**	↑	**0**	**(4,635)**	**4,635**	↑

Further detail of the budgets, actual spend and variances making up the main service areas above is provided in appendix 3.

2.1 Acute Services

Acute services include contracts with our main system acute providers as well as contracts with acute providers in Cornwall, Somerset, Bristol and London. It also includes our contract with South West Ambulance, contracts for patient transport and contracts for acute procedures undertaken in the independent sector and by other Non-NHS providers.

The ICB and system providers have agreed a set of block contract payments that also include top-up payments, growth funding and COVID allocations. The ICB's budget under these financial arrangements has been set to match the payments.

Overspends in this are due to:

- Patient transport costs, linked to increased journeys as a result of COVID and the discharge to assess policy.
- Pressure in relation to out of area non-contracted activity where patients are receiving treatment that is recharged to the ICB on a case-by-case basis.
- Payments to South Western Ambulance NHS FT for handover delays under a risk sharing agreement with the Trust.

An initial review of patient transport costs has been completed with a number of actions agreed that should reduce costs going forward and impact seen in the final

months of this financial year. These actions are linked to better planning and organisation of transport and are not expected to impact on patient care. A follow up review is planned in January.

2.2 Mental Health Services

The Mental Health budget commissions services for adult, children and young people. The main contracts for the services are with Devon Partnership NHS Trust (DPT) and Livewell Southwest with the CAMHS service for Northern, Eastern and Southern localities being provided by Children and Families Health Devon through a contract with Torbay and Southern Devon NHS Foundation Trust. This section also includes spend relating to individual adult placements for mental health and learning disability services.

The main area of overspending within mental health relates to individual patient placements driven by increasing numbers of placements for learning disability and individuals receiving care under s117 of the mental health act. A review has been completed with a number of actions agreed that should reduce costs going forward and impact seen in the final months of this financial year. The actions are linked to reviewing care packages to ensure they are providing the appropriate level of care. A follow up review is planned in January.

There are also pressures emerging relating to addressing ADHD waiting lists and SMI physical health checks that indicate a potential forecast overspend.

2.3 Community Health Services

Community Healthcare services include contracts with ICS partners for the provision of community healthcare (including community hospitals and children's services) as well as Minor Injury Units.

It also includes provision for community based acute procedures delivered through GP practice specialisms and other non-NHS providers as well as joint arrangements with Local Authorities under the provisions of the Better Care Fund.

Part of forecast overspend relates to a small number of high-cost individual placements. A review has been completed with a number of actions agreed that should reduce costs going forward some of which is already impacting on this month's position compared to Month 7. The actions are linked to reviewing care packages to ensure they are providing the appropriate level of care. A follow up review is planned in January.

The remaining overspend relates to increased costs of post discharge care under the discharge to assess policy that impacts on bed availability in our acute hospitals.

2.4 Continuing Care

Placements includes Continuing Care budgets comprising of Continuing Care Administration, Continuing Healthcare (CHC), Interim Funding, Joint Funding, Children's Continuing Care and Funded Nursing Care (FNC).

The placements budget represents a particular risk to the ICB financial position that requires robust financial management. The key risks relate to the backlog of CHC assessments and breaches from the continuation of 4-week Hospital Discharge Programme.

Some examples of other risks include:

- Fluctuations in the number of clients eligible for financial support
- Assessments exceeding 28 days
- Unexpected exceptional levels of support required for some clients
- Responsible commissioner cases

The Month 9 forecast position is £0.1m over budget which is an improvement of £1.2m from M8. This is largely a result of further mitigating actions on the high-cost cases. A forecast outturn overspend of £1.6m in FNC, partially offset by a £1.5m underspend in CHC.

Mitigating actions including high-cost case reviews are impacting on the position. The ICB has also commissioned an external provider to conduct reviews of the appropriateness of ongoing packages of care which is expected to reduce costs in January to March.

2.5 Other Programme

All Other Programme area picks up the remaining community-based provision of healthcare services including hospice care and other voluntary sector grant based commissioned services. This area also includes the element of our integrated urgent care contract that relates to NHS 111.

There are no particular issues to highlight in this area this month.

2.6 Primary Care Services

Primary Care includes expenditure on primary care prescribing, GP Medical Services (delegated from NHSE), enhanced services, Out of Hours and other primary care related expenditure including GP IT.

Prescribing

The prescribing position is being impacted by a cost pressure due to unavailability of the lowest priced stocks of medicines, an issue known as Price Concessions or No Cheaper Stock Obtainable (NCSO). The £9.1m forecast is being driven entirely by this cost pressure having set budgets on a flat cash basis which required savings of £5.7m.

As of month 9 the plan is on track to deliver and the medicines optimisation team have been challenged to go further than the initial plan and increase delivery in order to mitigate the NCSO cost pressure described above. 4 schemes have been identified targeting £600k and the team have been asked to prioritise their implementation.

Delegated Commissioning

The remaining forecast overspend in primary care is driven by an £6.7m anticipated cost in relation to additional primary care roles which is reimbursed on a retrospective basis by NHSE.

Other Primary Care

Other primary care services include contracts for enhanced GP services, out of hours GP services, home oxygen services and provision for GP IT costs.

2.7 Running Costs

The pay and associated costs for the ICB are categorised into administrative (running costs) and programme costs according to whether they relate to healthcare services and are solely concerned with management of the organisation.

Each year the ICB receives a specific allocation for its running costs and has an obligation to report against it separately and mustn't overspend against the limit set.

We are expecting to contain our running costs within the specified allocation this year.

2.8 Resource Allocation

Revenue resources contained within our financial plans and financial systems are set out below.

Allocation Description	Year to date		
	CCG M1-3 £000	ICB M9 £000	Total £000
Core allocation	520,549	1,538,927	2,059,476
Primary care commissioning	49,960	148,548	198,508
Ockenden maternity review	365	1,093	1,458
Running costs	5,645	16,933	22,578
Core - Additional Inflation Funding		22,720	22,720
Primary Care - Additional Inflation Funding		1,331	1,331
Recurrent Allocation	**576,519**	**1,729,552**	**2,306,071**
Health Inequalities Funding	931	2,794	3,725
COVID funding	11,828	35,482	47,310
Running cost pension contribution	340		340
Service development fund (SDF)	9,073	29,124	38,197
Elective Services Recovery Funding (ESRF)	9,874	29,623	39,497
CCG to ICB Transition Adjustment	(12,248)	12,248	0
Core - Additional Inflation Funding		7,123	7,123
New Allocations M4-M9		100,556	100,556
Non-Recurrent Allocation	**19,798**	**216,950**	**236,748**
Total Allocation	**596,317**	**1,946,502**	**2,542,819**

The new allocations from month 4 to month 9 include £30m relating to the changes in pay inflation and £23.9m demand and capacity funding to increase bed capacity over winter as well other known service development funds.

3. Savings And Efficiencies

The delivery of savings and efficiencies as at 31st December 2022 is as follows:

Scheme	RAG Status	Rec/ Non-Rec	% of Budget	Year to date			Forecast		
				Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000
Prescribing		R	2.7%	4,275	4,446	171	5,704	5,704	0
Running Cost Inflation		R	2.3%	396	396	0	525	525	0
Placements		R	3.7%	2,961	2,802	(159)	3,945	3,945	0
Primary Care Commissioning Review		R	0.8%	1,503	1,503	0	2,000	2,000	0
Commissioning Review		R	0.8%	2,250	2,250	0	3,000	3,000	0
Covid Reduction		NR	78.0%	2,700	2,700	0	3,600	3,600	0
Acute		R	1.4%	585	585	0	784	784	0
Unidentified		NR		1,980	0	(1,980)	2,967	2,546	(421)
SDF		NR	11.1%	4,002	6,421	2,419	6,000	6,421	421
Workstream stretch		NR		5,334	0	(5,334)	8,000	8,000	0
Total				**25,986**	**21,103**	**(4,883)**	**36,525**	**36,525**	**0**
Recurrent				11,970	11,982	12	15,958	15,958	0
Non-Recurrent				14,016	9,121	(4,895)	20,567	20,567	0
Total				**25,986**	**21,103**	**(4,883)**	**36,525**	**36,525**	**0**

The majority of identified savings plans are delivering to plan as at Month 9.

The Placements year to date savings plan is reported as being off plan, although currently actions taken to date are forecast to deliver the £3.9m savings target. The savings plan in this area focuses on reviews of high-cost placements, timely post discharge assessments and reviews of personal health budgets. In addition, the ICB has engaged an external assessment resource which is expected to realise further financial benefits.

Savings linked to placements have seen improved delivery from the previous month. Any further financial benefits related to placements will contribute to the unidentified savings within the plan.

The workstream stretch target was linked to the system plan delivery and has no identified opportunities released to date. The forecast delivery recognises that through other non-recurrent means the ICB is able to manage the non-delivery of this target (see risk section 4).

4. Risks

The assessment of financial risk (and mitigations) for the year ended 31st March 2023 as at 31st December 2022, is as follows.

Headline	Description	M8 £000	M9 £000	Movement £000	Risk at Plan £000
CIP shortfall	Non-delivery of workstream stretch efficiency	8,000	8,000	0	8,000
CIP shortfall	Non-delivery of unidentified CIP	2,967	2,967	0	2,967
CIP shortfall	Partial delivery of SDF Review efficiency	3,000	3,000	0	3,000
Hospital discharge	Unable to manage costs of hospital discharge within budgets set			0	2,500
Prescribing prices	Increases in prescription drugs prices	3,900	3,900	0	1,500
Total Risk		**17,867**	**17,867**	**0**	**17,967**
Non-Recurrent flexibility	Release of balance sheet accruals	7,734	7,734	0	7,376
s256 funds	Use of s256 funding held by Local Authorities	0	0	0	2,500
Allocations Review	Hold back further non recurrent allocations	3,453	3,453	0	0
Non-Recurrent flexibility	Other non-recurrent benefits	6,680	6,680	0	0
Total Mitigation		**17,867**	**17,867**	**0**	**9,876**
Net Risk		**0**	**0**	**0**	**8,092**

The ICB has identified risk to delivering a breakeven position of £17.9m at 31st December 2022. Risks relate to the delivery of the savings target and increases in prescription drug prices.

Actions including release balance sheet flexibilities and use of non-recurrent funding streams (including reviews of in year allocations) have been identified that fully mitigate the identified risk and preserves s256 funding for use in 23/24.

The balance sheet flexibilities comprise of accruals made in 21/22 that are not required to cover expenditure in 22/23 and include situations where estimates were made at 31st March 2022 due to the timing of delivery of accounts. Budgets have been adjusted to reflect the £7.7m benefit which is currently held in reserve.

Other non-recurrent benefits relate to expected allocations that have yet to be reviewed but where we have a high level of confidence that that they will cover expenditure already incurred or included within the forecast expenditure position.

5. Other Financial Information

5.1 Statement of Financial Position

The statement of financial position (SoFP) provides a snapshot of the ICB's financial position at that date. The SoFP is made of two parts which must always equal each other: the top part (total assets employed) which shows the ICB's assets and liabilities (what the ICB owns and is owed), and the bottom part (total taxpayers' equity) which shows how the ICB has been financed.

The ICB's position at 31st December 2022 is shown in appendix 1.

5.2 Capital

The ICB has spent £120k capital on IT equipment in the period ended 31st December 2022.

5.3 Better Payment Practice Code

The Better Payment Practice Code requires the ICB to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The ICB's current performance against the target of 95% is detailed below:

Better Payment Practice Code	M9	
	Number	£000
Non NHS Creditors - % of bills paid within target	99.72	99.35
NHS Creditors - % of bills paid within target	98.12	99.98

5.4 Cash

There are several key cash performance targets that ICBs are measured against; these are set out in appendix 2.

6. Recommendations

The Board is requested to:

Consider, review and discuss the ICB's performance and position as at the period ended 31st December 2022.

Appendices

Appendix 1: Statement of Financial Position

Statement of Financial Position	M9 £000
Property Plant & Equipment	2,903
Intangible Assets	187
Non Current Assest	**3,090**
Inventories	896
Trade & Other Receivables - NHS	1,696
Trade & Other Receivables - Non NHS	20,882
Cash & Cash Equivalents	1,247
Current Assets	**24,721**
Total Assests	**27,811**
Trade & Other Payables - NHS	(17,923)
Trade & Other Payables - Non NHS	(164,812)
Other Liabilities	(3,744)
Borrowings / Cash in Transit	(6,081)
Current Liabilities	**(192,560)**
Total Assets Employed	**(164,749)**
General Fund	(164,749)
Total Taxpayers Equity	**(164,749)**

Appendix 2: Cash

There are several key cash performance targets that the ICB is measured against:

Measure	Month 9
ICBs must operate within their Cash Drawdown Requirement *The cash drawdown requirement is based on the revenue and capital resource limits, amended for various non-cash items like depreciation. At present NHS England has calculated this to equate to £1,935m for Devon ICB for the period ended 31st March 2023 (excluding the 3 months relating to Devon CCG).*	66.5% of the Cash Drawdown Requirement has been utilised as at month 9 (66.7% is expected based on a straight-line trajectory at month 9).
ICBs daily and monthly forecasting accuracy and notional charges NHS England is working on implementing a regime of bank charges against ICBs based on the accuracy of daily and monthly cash forecasting*. The start date for any charges to flow through the scheme to the ICB has not yet been confirmed.	Notional charges amount to £16,751 for December.
The closing cash balance in the bank should be no greater than 1.25% of the monthly drawdown	The ICB has met the requirement to manage their cash balances at the bank on the last day of the month to be no greater than 1.25% of the drawdown for that month.

**Although forecasting is carried out as accurately as possible it sometimes difficult to predict 2 months in advance (the requirement by NHS England) the exact timings and amounts of all income received and all payments made.*

Appendix 3: Operating Expenditure

The detailed financial position as at 31st December 2022

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
NHS Royal Devon & Exeter Foundation Tru	276,258	276,259	(1)	368,830	368,830	(0)
NHS University Hospitals Plymouth NHS Tr	241,269	241,275	(6)	323,209	323,209	(0)
NHS Northern Devon Healthcare Trust	118,323	118,326	(3)	158,151	158,151	(1)
NHS South Devon Healthcare Foundation T	192,329	192,351	(22)	257,663	257,685	(22)
NHS Taunton and Somerset	7,645	7,645	0	10,193	10,193	0
NHS South Western Ambulance Trust	47,583	48,274	(691)	63,444	64,788	(1,344)
Independent Sector	29,525	29,361	164	39,367	39,176	191
Patient Transport	7,277	8,333	(1,056)	9,689	11,192	(1,503)
Other Acute	19,807	21,426	(1,619)	23,411	24,469	(1,058)
Acute	**940,017**	**943,252**	**(3,235)**	**1,253,956**	**1,257,693**	**(3,736)**
Devon Partnership NHS Trust	124,670	124,670	0	166,177	166,177	(0)
Livewell MH Services	4,703	4,703	0	6,287	6,287	0
University Hospitals Plymouth MH	30,771	30,771	0	41,040	41,040	(0)
Children and Families Health Devon	11,505	11,505	0	15,373	15,376	(3)
Individual Patient Placements	10,012	11,115	(1,103)	13,356	14,820	(1,464)
Section 117	15,605	16,371	(766)	20,855	21,828	(973)
Other Mental Health	6,487	6,191	296	8,622	9,210	(588)
Mental Health	**203,753**	**205,327**	**(1,574)**	**271,711**	**274,739**	**(3,028)**
Livewell Southwest	(184)	72	(256)	(185)	114	(299)
Royal Devon and Exeter Community	47,522	47,522	0	63,362	63,363	(0)
Northern Devon Healthcare Community	24,489	24,489	0	32,653	32,653	(0)
South Devon Healthcare Community	52,666	52,666	0	70,171	70,171	0
University Hospitals Plymouth Community	43,568	43,569	0	58,373	58,372	0
Children and Families Health Devon	9,676	9,676	0	12,925	12,925	0
Individual Patient Placements	634	1,110	(477)	834	1,480	(646)
Integrated Urgent Care Service	9	8	1	9	8	1
Hospices	6,198	6,131	67	8,264	8,178	87
MIU Contracts	604	561	43	806	760	46
Better Care Fund_Plymouth CC	4,138	4,138	0	5,878	5,878	(0)
Better Care Fund_Devon CC	21,915	21,914	1	29,220	29,219	1
Demand and Capacity	1,967	1,968	0	2,623	2,623	0
VCSE S256	-	(83)	83	0	8	(8)
Other Community Services	15,977	16,114	(137)	22,154	22,834	(680)
Community Health	**229,179**	**229,854**	**(675)**	**307,087**	**308,585**	**(1,498)**
Continuing Healthcare	99,143	98,121	1,022	132,187	130,679	1,508
Funded Nursing Care	10,862	12,087	(1,225)	14,497	16,116	(1,619)
Continuing Care	**110,005**	**110,208**	**(203)**	**146,684**	**146,795**	**(111)**

Service	Year to date			Forecast		
	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000	Plan £000	Actual £000	Variance Favourable/ (Adverse) £000
Prescribing	157,312	163,348	(6,037)	210,109	219,161	(9,052)
Enhanced Services	7,917	7,158	759	11,081	10,055	1,026
Delegated Commissioning	149,348	148,560	787	199,733	206,391	(6,658)
GP Out Of Hours	8,871	9,065	(194)	11,544	11,305	240
GP IT	3,103	3,121	(18)	4,149	4,166	(18)
Other Primary Care	11,123	8,952	2,171	13,618	11,399	2,219
Primary Care	**337,673**	**340,204**	**(2,531)**	**450,235**	**462,477**	**(12,242)**
NHS 111	7,320	6,849	470	9,741	9,670	71
Better Care Fund Torbay	2,749	2,749	0	3,665	3,665	0
Chime Audiology	2,900	2,976	(76)	3,867	3,953	(86)
All Other Commisionned Services	15,318	14,496	823	20,485	19,664	821
Other Programme	**28,287**	**27,070**	**1,217**	**37,758**	**36,952**	**806**
Total Commissioned Services	**1,848,914**	**1,855,915**	**(7,001)**	**2,467,430**	**2,487,241**	**(19,810)**
Pay	13,619	14,095	(476)	18,045	18,046	(0)
Non Pay	3,742	3,955	(213)	4,990	4,990	0
Income	(87)	(125)	38	(117)	(116)	(0)
Running Costs	**17,274**	**17,925**	**(651)**	**22,919**	**22,919**	**(0)**
Net Expenditure	**1,866,188**	**1,873,840**	**(7,652)**	**2,490,349**	**2,510,160**	**(19,811)**
Reserves/Contingencies	39,143	28,402	10,741	52,470	36,094	16,376
Total Net Expenditure	**1,905,331**	**1,902,242**	**3,089**	**2,542,819**	**2,546,254**	**(3,435)**
Resource Allocation	(1,905,331)	(1,905,331)	0	(2,542,819)	(2,542,819)	0
Additional Roles Reimbursement Scheme	0	0	0	0	(8,070)	8,070
Total Commissioned Services	**0**	**(3,089)**	**3,089**	**0**	**(4,635)**	**4,635**

NHS Devon

NHS Devon Integrated Care Board

NHS Devon (ICS) Finance Report Month 9

Date of committee	Date report produced
15 February 2023	2 February 2023

Author(s)		Report approved by	
Name and title:	Kevin Wheller Associate Director of Finance	**Name and title:**	Bill Shields Director of Finance
Phone:	07825 027569	**Date:**	2 February 2023
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If this paper needs to be presented at a private meeting, please state why and mark as CONFIDENTIAL:

Executive summary

The presentation of the Integrated Care System's (ICSs) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2023.

The report details the ICS financial position for the period ended 31 December 2022 against the finance plan submitted on 20 June 2022, setting out the year to date and forecast financial position as well as the risks to delivery of that forecast.

Committees that have previously discussed/agreed the report, and outcomes of that discussion
Finance Committee approved the report on the 1st February

Key recommendations and actions requested
The Board is requested to: Consider, review and discuss the ICB financial position as at the period ended 31 December 2022.

Impact on NHS Devon objectives	
Objective	**Impact**
Make more efficient use of our resources	To enable the delivery of the ICB control total

Does this report have implications in any of the areas highlighted below?		
Area	**Yes (summarise implications)**	**No**
Quality of services		√
Health inequalities		√
Workforce		√
Resources and finance	Delivery of financial sustainability	
Legal		√
Engagement and consultation		√

NHS Devon has made every effort to ensure this report does not discriminate (directly or indirectly) against employees, patients, contractors, or visitors on grounds of race, colour, age, nationality, ethnic (or national) origin, sex, sexual orientation, marital status, religious belief or disability.

NHS Devon Integrated Care System

Finance Report

Month 9 – 2022/23

Contents

1. Executive Summary

The presentation of the Devon Integrated Care System's (ICS) Finance Report seeks to provide the necessary assurance to the Board on the current and projected financial position of the ICS for the year ended 31 March 2023.

This report details the ICS financial position as at 31 December 2022.

On 20 June 2022, Devon ICS submitted a deficit plan of £18.2m although there is a requirement that the system achieves a breakeven outturn by year end. For 22/23 the system has received a reduced COVID envelope from 21/22. Some COVID funding will be reimbursed on top of the system envelope, this includes spend on testing and vaccinations.

As at month 9 the Devon ICS is reporting a year to date £29.3m deficit against a planned deficit of £17.4m – an adverse variance of £11.9m (M8 £7.4m variance) The reported forecast is a deficit of £49.5m which is £31.3m adverse to the planned deficit of £18.2m. (M8 £0 variance)

The movement in forecast outturn was signed off by the ICB board in December and discussed and agreed at the previous finance committee as detailed in section 3 of this report.

Agreement was gained from NHSE to move the forecast position and the relevant protocols were followed.

Efficiency savings of £138.9m are required to meet the June plan. As at month 9 the Devon ICS had made efficiency savings of £73.1m (M8 £64.4m) This is £24.5m adverse to plan. (M8 £19.8m). Forecast savings are adverse to plan by £35.1m (M8 £29.8m).

At the planning stage net risks of £95.9m were identified to delivery of a break-even plan. At the end of month 9, this has improved by £46.4m and stands at £49.5m (M8 £51.8m) is against an expectation of break-even (£31.3m against plan) and £0 risk to the current forecast.

The above position represents the reported position to NHSE as at Month 9.

2. Financial Performance

The year to date and outturn by organisation as at 31 December 2022 is as follows.

Organisation	Year to date				Forecast			
	Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000		Plan Surplus/ (Deficit) £000	Actual Surplus/ (Deficit) £000	Variance Favourable / (Adverse) £000	
Devon ICB	0	3,090	3,090	↑	0	4,635	4,635	↑
Royal Devon University NHS FT	(12,838)	(12,838)	0	→	(18,263)	(18,263)	0	→
University Hospitals Plymouth Trust	(2,315)	(7,317)	(5,002)	↓	0	(17,250)	(17,250)	↓
Torbay and South Devon NHS FT	(1,666)	(11,661)	(9,995)	↓	69	(18,622)	(18,734)	↓
Devon Partnership Trust	(605)	(606)	0	→	0	0	0	→
Total	**(17,424)**	**(29,332)**	**(11,908)**	↓	**(18,194)**	**(49,500)**	**(31,349)**	↓

As at month 9 the Devon ICS is reporting a year to date £29.3m deficit against a planned deficit of £17.4m – an adverse variance of £11.9m (M8 £7.4m variance)

The reported forecast is a deficit of £49.5m which is an adverse variance of £31.3m to the planned deficit of £18.2m. (M8 £0 variance).

3. Forecast Outturn Changes

The ICB Board received a paper on 21st December detailing the request to approve a revised forecast both for the ICB but also for the wider Devon system to be reported in Month 9.

The recommendations approved by the Board were:

- Agreement to change the ICB and system forecast at Month 9 to £2.135m surplus for ICB and £52m forecast deficit for Devon system.
- Delegated authority to the ICB Finance Committee for any further changes between now and Month 9 submission resulting from conversations and agreement with region.
- Signed off the ICB and system protocol document on the understanding that all organisation protocols and any outstanding actions will be reviewed by the ICB Finance Committee prior to submission.

The table below shows a bridge of the changes from the planned risks of £95.9m (against a breakeven plan) have improved / deteriorated to crystalise the position at the revised forecast outturn of £52m deficit.

	TSD	UHP	DPT	RDUH	ICB	Total
Plan risks and mitigations	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**	**£,000**
Gap to breakeven	69			-18,263		-18,194
CIP shortfall including COVID and Workstream stretch	-19,400	-8,000	-3,450	-3,000	-10,967	-44,817
ESRF related	-2,253	-1,750	-	-12,100	-	-16,103
Increase in inflationary costs forecast above included in plan	-	-2,750	-1,000	-3,200	-	-6,950
Integrated care contract	-6,000	-	-	-	-	-6,000
High cost drugs not met by income	-1,314	-1,000	-	-	-	-2,314
Prescribing Prices	-	-	-	-	-1,500	-1,500
Other	-765	-900	-6,095	-4,700	-5,500	-17,960
Balance sheet flexibility/non recurrent actions/funding	-	1,000	2,000	3,700	7,376	14,076
s256 Funds	-	-	-	-	2,500	2,500
Further Excess inflation funding	-	1,375	-	-	-	1,375
Risk to breakeven plan	**-29,663**	**-12,025**	**-8,545**	**-37,563**	**-8,092**	**-95,888**
Improvement / (deterioration) from plan						
CIP improvement	12,159	920	850	631	-1,050	13,510
ESRF related	2,253	-370	-	-2,627	-	-744
Integrated care contract increased costs	-4,102	-	-	-	-	-4,102
High cost drugs increased costs	-4,636	-2,000	-	-3,939	-	-10,575
Prescribing Prices increases	-	-	-	-	-2,400	-2,400
Pay awards not covered by funding	-	-1,600	-434	-1,251	-	-3,285
Other risk decreases / (increases)	-7,518	-3,300	5,338	3,552	5,500	3,572
s256 Funds	-	-	-	-	-2,500	-2,500
Underspends / slippage	1,635	-	591	10,344	-	12,570
Additional funding specialist	-	3,500	-	-	-	3,500
Hold back further non recurrent allocations	-	-	-	-	3,000	3,000
Other mitigation	11,250	-2,375	2,200	12,590	7,677	31,342
Net Improvement	**11,041**	**-5,225**	**8,545**	**19,300**	**10,227**	**43,888**
Forecast Outturn	**-18,622**	**-17,250**	**-**	**-18,263**	**2,135**	**-52,000**

The main areas of risk that have not been fully managed and that contribute to the £33.8m deterioration in forecast (£18.2m deficit movement to £52m deficit) are summarised below:

- Shortfall in CIP delivery across all organisations £31.3m
- Elective Services Recovery related across the 3 Acute Trusts £16.8m
- Increased inflationary costs £7.3m
- Integrated Care Contract for TSD £10.1m
- High-Cost Drugs across the 3 Acute Trusts £12.9m
- Prescribing Costs for the ICB £3.9m
- Shortfall on available funding for pay award £3.3m

These have been offset by the following mitigations:

- Balance sheet flexibility and non recurrent funding/actions £17.1m
- Underspends and slippage £12.6m
- Additional specialist funding £3.5m
- Other mitigations £18.6m

Since the Board approved the £52m deficit revised position further national support of £2.5m has been notified. This additional support is to help improve the position of systems in deficit therefore the revised Month 9 forecast is £49.5m.

Further discussions will take place within the system to identify how this additional support will be distributed and amendments made at M10 forecast. As this will be a net neutral change to the system in Month 10 it does not require further permission from region or national teams.

As part of changing the forecast at month 9 the following actions were required and have been undertaken:

- Signed protocols from Boards/Finance Committees confirming compliance
- Report to NHSE to support the change in forecast – SW regional finance have confirmed that the report to the Finance Committee fulfils this action
- SW Regional Finance colleagues invited to attend Finance Committee

4. Savings And Efficiencies

The delivery of savings and efficiencies as at 31 December 2022 is as follows:

Organisation	Year to date				Forecast			
	Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000		Plan CIP Delvery £000	Actual CIP Delivery £000	Variance Favourable / (Adverse) £000	
Devon ICB	25,984	21,103	(4,881)	↓	36,525	36,525	0	→
Royal Devon University NHS FT	24,341	13,161	(11,180)	↓	33,935	17,567	(16,368)	↑
University Hospitals Plymouth Trust	19,613	18,572	(1,041)	↓	29,592	23,163	(6,429)	↓
Torbay and South Devon NHS FT	20,703	14,829	(5,874)	↓	28,452	18,010	(10,442)	↑
Devon Partnership Trust	6,974	5,476	(1,498)	↑	10,358	8,542	(1,816)	↑
Total	**97,615**	**73,141**	**(24,474)**	↓	**138,862**	**103,807**	**(35,055)**	↓

As at month 9 the Devon ICS had made efficiency savings of £73.1m (M8 £64.4m) This is £24.5m adverse to plan. (M8 £19.8m).

Forecast savings are adverse to plan by £35.1m (M8 £29.8m).

5. Risks

The assessment of financial risk (and mitigations) for the year ended 31 March 2023 as at 31 December 2022, is as follows.

Description	Net Weighted Risks & Mitigations						Net Risks at Plan
	ICB £000	RDUH £000	UHP £000	TSD £000	DPT £000	Total £000	£000
CIP shortfall	(13,967)	(16,665)	(1,000)	0	(2,210)	(33,842)	(47,817)
Forecast Surplus/(Deficit)	4,635	(18,263)	(17,250)	(18,622)		(49,500)	(18,194)
Increase in inflation		(2,500)	0	0	0	(2,500)	(6,950)
Integrated care contract				0		0	(6,000)
Hospital discharge	0					0	(2,500)
High cost drugs not met by income		(3,104)	0	0		(3,104)	(2,314)
Clinical excellence awards			0	0		0	(1,665)
Pay inflation shortfall		(1,251)	0			(1,251)	
IFRS 16			0			0	
Specialist commisioning rebase					0	0	(1,500)
Prescribing prices	(3,900)					(3,900)	(1,500)
OOA and staffing support					0	0	(1,300)
IPP service growth					(338)	(338)	(1,250)
MHIS and SDF income risk					0	0	(1,200)
ERSF risks						0	(16,103)
Other		(3,271)	0	(4,300)	(1,108)	(8,679)	(5,545)
Total Risk	**(13,232)**	**(45,054)**	**(18,250)**	**(22,922)**	**(3,656)**	**(103,114)**	**(113,838)**
Non-Recurrent flexibility	14,414	26,791	1,000	4,300	3,656	50,161	14,076
s256 funds, or exit strategy	3,453					3,453	2,500
Spec com income						0	0
ERSF mitigation						0	0
Further Excess inflation funding						0	1,375
Total Mitigation	**17,867**	**26,791**	**1,000**	**4,300**	**3,656**	**53,614**	**17,951**
Net Risk	**4,635**	**(18,263)**	**(17,250)**	**(18,622)**	**0**	**(49,500)**	**(95,888)**

Month 8	**5,000**	**(20,912)**	**(17,250)**	**(18,657)**	**0**	**(51,819)**

Movement	**(365)**	**2,649**	**0**	**35**	**0**	**2,319**

At the planning stage risks of £113.8m were identified along with £18.0m of mitigations, leaving a net risk of £95.9m to delivery of a break-even plan.

As at month 9 the net risk has reduced to £49.5m against break-even (M8 £51.8m) and is a £0 risk against the forecast outturn deficit of £49.5m.

There are £53.6m risks (of which £33.8m relate to CIP) to the current forecast with £53.6m mitigations.

The revised position of £49.5m deficit is still exposed to further risk. Careful management of this risk is required during Quarter 4 to ensure that the revised position is delivered. No subsequent deterioration in the position is acceptable and will be deemed as poor financial control.

The current monthly risk and mitigations process will continue until year end and be reported through the ICB Finance Committee. The main residual system risks remaining that are either outside of our control or require careful management are:

- Delivery of remaining CIP included in plans

- Additional costs associated with winter pressures and surges in COVID and flu (for example workforce backfill.
- Further inflationary increases and increased utility costs if further cold spells.

These risks with be managed throughout the final quarter as follows:

- Liaison with operational colleagues – an assessment of the impact of winter and pressure on urgent care will be provided by the COOs as part of regular operational updates that will be provided to the Executive Finance and Performance Group that meets weekly.
- Executive oversight of the financial position will continue at an organisational level.
- The DOFs will continue to meet weekly where any known variance to forecast will be reviewed and mitigations sought to keep the system position on track.
- The Executive Finance and Performance Group has had its meeting frequency changed from monthly to weekly and membership expanded to include CEOs, CFOs, COOs, and workforce representation. This will enable it to swiftly respond to any intelligence received in terms of workforce/activity/performance and finance.
- The monthly risks and mitigations process will continue as part of monthly financial reporting to the ICB Finance Committee.

6. Capital

System capital

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	22,343	16,775	5,568	↑	33,306	33,306	0	→
University Hospitals Plymouth Trust	14,347	11,266	3,081	↑	24,080	24,080	0	→
Torbay and South Devon NHS FT	14,932	12,655	2,277	↑	18,371	18,371	0	→
Devon Partnership Trust	5,156	3,010	2,146	↑	7,448	7,448	0	→
Total	**56,778**	**43,706**	**13,072**	↑	**83,205**	**83,205**	**0**	→

System Capital spend is under plan at month 9 by £13.1m (M8 £7.9m)

Forecast system capital spend is on plan as at M9.

Total Capital

Organisation	Year to date				Forecast			
	Plan £000	Actual £000	Variance Favourable / (Adverse) £000		Plan £000	Actual £000	Variance Favourable / (Adverse) £000	
Royal Devon University NHS FT	33,806	25,122	8,684	↑	50,562	52,487	(1,925)	↓
University Hospitals Plymouth Trust	30,583	17,303	13,280	↑	88,480	93,799	(5,319)	↓
Torbay and South Devon NHS FT	19,617	18,884	733	↑	27,007	43,299	(16,292)	↓
Devon Partnership Trust	5,156	3,191	1,965	↑	7,448	11,893	(4,445)	→
Total	**89,162**	**64,500**	**24,662**	↑	**173,497**	**201,478**	**(27,981)**	↓

The total capital plan includes impact of IFRS16 on leases.

Total capital spend is under plan by £24.7m as at month 9. (M8 £18.9m) and the forecast spend on capital by end March 2023 is over plan by £28.0m. (M8 £14.0m).

The plan is fixed at submission and not updated as subsequent schemes are approved and PDC awarded so these schemes then show as an overspend.

7. Recommendations

The Board is requested to:

Consider, review and discuss the ICB financial position as at the period ended 31 December 2022 including the risks to delivery of the revised forecast.

NHS Devon Integrated Care Board

Committee Chair Report – Finance Committee

Date of Board Meeting	Date of committee covered in this report
15 February 2023	1 February 2023

Chair	
Name and title:	Kevin Orford, Non-Executive Member, Finance and Remuneration

Reports discussed and assurances received

Integrated Performance and Quality Report
The Report was reviewed and noted with reference to the discussion at the Quality and Performance Committee.

ICS Finance report. Position to end of December 2022 and Year End Forecast.
The report was received, noting, the revised forecast year-end Devon System financial position of £49.5m deficit, an adverse variance of £31.3m to the original plan. The Committee received assurances that processes are in place to actively manage the delivery of the revised forecast. The Committee also received assurance that processes are in place to manage the year end position on capital expenditure.

ICB Finance Report
Report received and assurances received re delivery of the 22/23 financial plan for ICB.

Operational Plan 2023/24 Update

The Committee received assurances on the rigour with which the operational planning process is being conducted. The timeline for engagement and agreement of Boards was discussed and it is proposed that the Interim Plan submission in February might be best agreed through the Chairs/CEOs meetings, but that each Board would need to approve the final submission before the end of March. Issues discussed by the Committee were:

- The Committee noted the NHS national requirements of the ICB as set out in the Operating plan guidance and in meetings with the regional and national NHS teams during January. The Committee supported the approach of the ICB Chief Executive Officer and executive directors to meet those requirements and the committee thanked the Chief Financial Officer for his leadership on the development of the plan.
- The Committee supported the scenario methodology to developing the plan, noting that the approach had been agreed by the system organisations.
- The team has a focus on the Local Authority interface, particularly where changes to Local Authority investment impact on NHS services. Where there is a likely impact, NHS Boards need to have an understanding of that and to have a plan to manage associated risk.
- Cost Improvement schemes will be “stress tested” and clear articulation of productivity improvement.
- The team recognises the need for a clear and credible system transformation narrative to support the plan.
- Explicit governance processes relating to ICB and Trust Board engagement are being finalised in order that each Board is able to approve the final submission in knowledge of the scale of risk inherent in the plan and an understanding of the means to manage those risks.
- The Committee noted the particular challenges around the alignment of workforce plans to the Operational Plan and noted that system workforce directors are fully engaged in the planning process.
- The committee noted the importance of planning for the necessary financial “run rate” to be delivered across the system from April 2023 to ensure that financial management is addressed from the start of the financial year.

Reports received and noted

Financial Framework 2023/24. Reviewed and noted.
Section 75 Agreements. Update on proposals for internal review of S75 arrangements.

Board Assurance Framework

The Committee noted that there is further work to be undertaken relating to the articulation of the financial risk in the Board Assurance Framework. It was agreed that attempts would be made to address this outside of the meeting before the next Board meeting and it was also noted that there are significant other demands on the resources of the finance team.

Committee decisions
N/A

Items of concern to be escalated to the board
N/A

Recommendations for the board
N/A

Recommendations for other committees
N/A

Terms of reference or other committee effectiveness issues
N/A

NHS Devon

NHS Devon Integrated Care Board

Committee Chair Report – Primary Care Commissioning Transitional Committee

Date of board meeting	Dates of committees covered in this report
15 February 2023	26 January 2023

Chair	
Name and title:	Thandiwe Hara, Non-Executive Director Citizen and Community Engagement
Phone:	
Email:	thandiwe.hara@nhs.net

To be noted that this was a shortened meeting containing a presentation and Deputy Director updates only.

Reports discussed and assurances received

- The committee received a presentation by the NHSE Southwest director for specialised health and the programme manager in charge of primary, secondary and community contracts, on the position of **Dental services** in Devon and their commissioning challenges.

Reports received and noted

Deputy Director's report highlighted

- Additional hotel asylum seeker and refugee accommodation in Exeter
- A formal offer of a 6-month contract extension for a provider in Plymouth and the confirmation of a date for submission of their transformation plan to the

ICB.
- The signing of a new contract model for a practice in Torbay which was in need of additional partners.

Risk register review updates

- None

Committee decisions

- None

Items of concern to be escalated to the board

- None

Recommendations for the board

- None

Recommendations for other committees

- None

Terms of reference or other committee effectiveness issues

- None

NHS Devon

NHS Devon Integrated Care Board

Committee Chair Report – People & Culture Committee

Date of board meeting	Dates of committee covered in this report
15 February 2023	25 January 2023

Chair	
Name and title:	Dr Thandiwe Hara, Non-Executive Director of Inequalities and Population Health

Reports discussed and assurances received

Paul Renshaw presented the Director of Strategic Workforce Report to the committee with updates on:

Workforce Strategy
First draft narrative will come to the People and Culture committee in February with ICB Board feedback to be gained in March. We expect that the final narrative and numerical plan will be completed by the end of Q1 2023/24.

Workforce planning
An agreed specification for a Strategic Workforce Planning (SWP) tool has been developed which received approval for funding through HEE workforce development funding in January 23. We are now proceeding to procurement business case and subject to approval, the build of the SWP tool for the pilot phase will commence in Q1 FY 23/24.

We then expect full roll out of the tool during 2023 and once embedded in Devon for health, primary and social care, we will share with Regional and National colleagues since this is ground-breaking work that doesn't yet exist other than from commercial

organisations selling into the NHS.

Collaboration of banks
A Task & Finish Group has been set up to maximise the savings potential through increased use of the Southwest Locum Collaborative Bank. The collaborative model enables Trusts to benefit from directly sourced locum resource, reducing reliance on more costly agency locum resource. We are working with the external provider of the collaborative Bank software, as well as resourcing leads to identify targeted areas for further savings and improvement opportunities.

Social care resourcing /upskilling and retention
A business case has been produced and funding is now being sought from within system funds in order to extend across Devon the Livewell and PCC approach to social care recruitment. A funding decision is expected in April as part of the Operational plan process.

Work is progressing to agree how we can upskill some social care workers to take on some of the services (e.g. wound care) from NHS colleagues.

Workforce productivity and efficiency update (year to date data)
Staff turnover – 7.8% (8.8% region)
Absence – 6.2% (5.7% national)
Vacancies – 1,989 (increase of 350 compared to last year)

There is a predicted agency overspend.

Phill Adams, Senior Manager Skills – Devon County Council presented an update on the Health and Social Care Skills Accelerator programme (HASSAP) which was allocated a total of £3.5million for an EDI Fund skills and training programme working alongside with trusts, providers, Trainers and Educational partners.

The programme has generated around 1,500 training and employment opportunities with around 500 people securing a formal qualification. Looking ahead to the next 12 months, the programme is due to engage with a further 1,800 residents, with training and provider partners due to offer around 600 additional training places by the end of the Calendar. It should be noted however that 25-30% of these 2023 opportunities are already full, with a new cohort starting in the first week of January.

Tracey Collins, International Nursing Workforce Lead – Devon Alliance. The Alliance continues to meet demand requirements. We have successfully deployed over 700 nurses into NHS providers over the past 16 months and plans are being agreed for 2023/24 activity.

A campaign for SWAST underway for 10 Triage Nurses.

The Social Care International Recruitment Programme is underway with first 5 care Workers arriving this month. c900 Care Worker applications still being reviewed & the IR Hub are currently matching Care Worker CVs for 42 providers.

We have also made offers to overseas candidates to:

- 24 AHP's
- 21 Diagnostic Radiotherapists
- 3 Occupational Therapists.

Paul Renshaw presented to the committee the workforce challenges report which would also be presented at the NHS Devon Board in February. Paul informed the committee that the report provides a summary of the key challenges affecting the workforce agenda across the Devon System and the key highlights and actions that are being taken to address them.

The key workforce challenges are;

- Recruitment & Retention of staff
- Agency spend
- Staff absence and wellbeing
- Workforce strategy and planning

Reports received and noted

- Director of Strategic Workforce Report was presented to the committee and noted.
- HASSAP Report was presented to the committee and noted.
- International Recruitment Report was presented to the committee and noted.
- ICB Board Summary Report on Workforce challenges was presented to the committee and noted.

Risk register review updates

The committee reviewed the latest version of the BAF workforce risk as shown below:

Risk (4) If the ICB does not produce an agreed system-wide workforce strategy that meets the health and care needs of the population, is affordable and can be delivered by system partners, then it will continue to have high costs and be unable to ensure resilient, safe, and effective services. As a consequence the ICB will continue to fail to meet statutory constitutional targets.

It was then agreed a slightly amended version that highlights that the ICB needs to ensure that system partners deliver against this strategy as shown below:

Risk (4) If the ICB does not produce an agreed system wide workforce strategy and does not ensure delivery by system partners of a plan that meets the health and care needs of the population and is affordable, then One Devon will continue to have high costs and be unable to ensure resilient, safe, and effective services. As a consequence the ICB will continue to fail to meet statutory constitutional targets.

Committee decisions

- Nil

Items of concern to be escalated to the board

- Nil

Recommendations for the board

- Nil

Recommendations for other committees

- Nil

Terms of reference or other committee effectiveness issues

- Nil

Management of conflict of interests:

Conflicts of interests are recorded on the register of interests. At each committee, a list of recorded declarations is provided. New declarations must be raised, recorded and included in the minutes of the meeting and notified to the Governance team via d-icb.governance@nhs.net to update the central register.

NHS
Cornwall and
Isles of Scilly

Paper number: ICB2223/128

Board meeting of the Integrated Care Board

Agenda item: ICB chief executive update

Date of meeting: 9 February 2023
Meeting section: Public session (part 1)
For: Discussion

Author: Kate Shields, chief executive

1. Executive summary

The chief executive's update is a regular feature of each board meeting.

The report focuses on highlighting emerging issues and significant developments that are not otherwise covered on the board agenda. It helps ensure members are aware of key areas of work happening within the Cornwall and Isles of Scilly integrated care system (ICS).

A verbal update on other key areas may also be given.

2. Recommendations

The ICB Board is asked to receive the chief executive update and enquire further, as necessary.

3. Main report

3.1 NHS England / Department of Health and Social Care: Delivery plan for recovering urgent and emergency care services (January 2023)

On 30 January Dame Ruth May, Sir David Sloman, Professor Stephen Powis and Saraj-Jane Marsh, of NHS England wrote to all Integrated Care Board and Trust Chief Executives to advise of the new 'delivery plan for recovering Urgent and Emergency Care services'.

This is a joint NHSE and DHSC delivery plan and is part of a key commitment given in the autumn statement.

NHS Cornwall and Isles of Scilly Integrated Care Board
Call us on 01726 627 800
Email us at ciosicb.contactus@nhs.net
Visit our website: cios.icb.nhs.uk

Part 2S, Chy Trevail,
Beacon Technology Park,
Dunmere Road,
Bodmin, PL31 2FR
Chair: John Govett
Chief executive officer: Kate Shields

The plan includes two ambitions for the next two years – (i) a 30-minute mean response time for Category 2 ambulance and (ii) 76% performance in A&E wait times, measured through the 4-hour target. Improvements are required across the patient pathway, including on 12-hour waits from arrival and on discharge from acute, community and mental health hospital settings.

The plan sets out actions across five key areas:

- Increasing capacity – investing in more hospital beds and ambulances, but also making better use of existing capacity by improving flow.
- Growing the workforce – increasing the size of the workforce and supporting staff to work flexibly for patients.
- Improving discharge – working jointly with all system partners to strengthen discharge processes, backed up by more investment in step-up, step-down and social care, and with a new metric based on when patients are ready for discharge, with the data published ahead of winter.
- Expanding and better joining up health and care outside hospital – stepping up capacity in out-of-hospital care, including virtual wards, so that people can be better supported at home for their physical and mental health needs, including to avoid unnecessary admissions to hospital.
- Making it easier to access the right care – ensuring healthcare works more effectively for the public, so people can more easily access the care they need, when they need it.

To support the recovery plan, the government has committed to additional targeted funding including:

- £1 billion of dedicated funding for 2023/24 to support capacity in urgent and emergency services, **as set out in the Planning Guidance**, and to increase overall capacity and support their staff.
- £1.6 billion of additional funding in the Adult Social Care Discharge Fund in 2023/24 and 2024/25, to be pooled into the Better Care Fund (BCF)

It must be noted it is clear the money is already committed via the planning guidance and the ASC discharge fund will be delivered through the BCF. Additional beds will be subject to demand and capacity work and be allocated where needed. CIoS have already identified they are over bedded so therefore unlikely to receive more funding for increasing bedded capacity.

The full document can be accessed through this link:

NHS England » Delivery plan for recovering urgent and emergency care services

3.2 Industrial Action Update

Industrial action has continued with the most recent being the two days affecting RCHT and SWAST. There is ongoing action through February and our system response is co-ordinated through the industrial action group that meets daily, reporting into the System Coordination Centre (SCC). System colleagues pulled together brilliantly during the latest periods of IA with constructive working relationships maintained and our thanks go to everyone who is working hard to manage the ongoing disruption.

3.3 System Oversight Meeting

A System Oversight Meeting (SOM) was held on 31 January 2023 involving representatives from across the CIOS health and care system, with colleagues from NHSE England, SWAST, Care Quality Commission and the Local Government Association. These meetings are held on a 4–6-week basis. The purpose of the SOM is a focus on discharges and no criteria to reside improvements. The discussions at the recent meeting also focused on Elective and Cancer activity and trajectories, Mental Health (including IAPT and Dementia), and workforce matters.

Integrated Care Board Meeting - Action Log								
Action Number	**Date of Meeting**	**Action - issue to be addressed**	**Target Date**	**Lead**	**Progress on action**	**Date Closed**	**By whom**	**OPEN/CLOSED**
24	16.11.22	Investigate the points raised by the patient relating to his experience whilst waiting for treatment of NDHU and follow up with the patient and the Chair	Dec-22	Darryn Allcorn	11.01.23 - A response has been sent to the patient from the trust. A final copy is being requested to allow the Chair to also write to the patient. 08.12.22 - Darryn Allcorn has raised some concerns with NDUH N and had some responses. Darryn will write to the patient and copy in the Chair once a couple of points have been clarified.			**In progress**
26	21.12.22	The Devon Audit Chairs' forum to hold a risk review workshop and feed back to the board, via the Audit committee Chairs report	Feb-23	Graham Clarke	31.01.23 - On hold whilst exploring partnership working arrangements 05.01.23 - Dates are being reviewed for the workshop			**In progress**
27	18.01.23	Asylum seeker programme to be included on forward planner to discuss further.	Feb-23	Jodie Howland	26.01.23 - added to forward planner for May 2023 as a place holder. Request to close			**Request to close**
28		Provide feedback the after action review of operational changes, discharge funding evaluation and virtual ward progress at the next meeting	Mar-23	Anthony Fitzgerald	08.02.23 - Paper deferred to March to enable analysis and evaluation via the Finance committee before being presented back to the board.			**In progress**